**Please fax referral to (416) 785-4235**

**or email to neuropsychreferrals@baycrest.org**

# REFERRAL FORM

| **Client Information** | | | |
|---|---|---|---|
| Client name | Age | Date of birth (dd/mm/yyyy) | |
| Client's address | City | Postal code | |
| Client's email address (if client has agreed to be contacted by email) | | | |
| Home phone | Other phone | Health card number | Version code |
| Principle contact | Relation to client | Contact's email | Phone number |

| **Referring Source Information** | | |
|---|---|---|
| Name of referring physician/healthcare professional | Telephone | Fax |
| Discipline | Agency | |
| Date of referral (dd/mm/yyyy) | | |

| **Etiology** |
|---|
| ☐ Stroke ☐ Anoxia ☐ Tumor ☐ Surgery ☐ Radiation Therapy ☐ TBI ☐ Encephalitis<br>☐ Multiple Sclerosis ☐ Wernicke/Korsakoff ☐ Other |
| Please specify |
| Date of injury/event (dd/mm/yyyy) |

| **Reason for Referral** |
| --- |
| *This program is for adults who are experiencing difficulties forming and retaining new memories. It is focused on training in the use of commercial technologies (e.g., smartphones and tablets) as memory aids towards improving day-to-day functioning and independence.* |
| Specify memory challenges/rehab goals |

| **Professional Reports** |
| --- |
| ☐ Neuropsychological ☐ Occupational Therapy ☐ Speech Pathology ☐ Social Work ☐ Neurology |
| Please summarize and attach all available reports |

| **Neuroimaging** |
| --- |
| ☐ MRI Results ☐ CT Results ☐ SPECT Results ☐ PET Results |
| Please summarize and attach all available reports |

| **Relevant Medical History** |
| --- |
| Previous history of ABI |
| Previous psychiatric history |
| Current psychiatric status |
| History of substance abuse |
| Seizures |
| Other |