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)		

Brain Injury Etiology
☐ Stroke ☐ Anoxia ☐ Tumor ☐ Surgery ☐ Radiation Therapy ☐ TBI ☐ Encephalitis ☐ Multiple Sclerosis ☐ Wernicke/Korsakoff ☐ Other (we do not accept neurodegenerative conditions)
Please specify
Date of injury/event (dd/mm/yyyy)

Reason for Referral
*This memory rehabilitation program is for adults who are experiencing difficulties forming and retaining new memories, due to an acquired brain injury (ABI). **This program is NOT for diagnostic assessment.***
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