REFERRAL FORM

Date of referral _____ Is this a referral to the North Shore Memory Clinic? Yes / No

Does this referral relate to a current or potential medicolegal matter? Yes / No
Does this referral relate to injuries sustained in an automobile accident? Yes / No
Does this referral relate to a workplace injury? Yes / No

PATIENT NAME _____ DOB _____ Age _____ ☐ M ☐ F
Address _____
Phone (home) _____ Phone (work) _____ Phone (cell) _____
Email _____

REFERRAL INFORMATION
Referring person: Self OR _____ of _____(office)
Address _____
Phone _____ Fax _____
Email _____

Main referral question (i.e. what do you want to learn from, or get out of, this evaluation?):
_____
_____
_____

Pertinent diagnoses or history:
☐ Concussion / mild brain injury ☐ Moderate to severe brain injury
☐ Stroke ☐ Multiple sclerosis
☐ Dementia or mild cognitive impairment ☐ Parkinson's disease
☐ Other neurological disorder_____
☐ Post-cancer treatment ☐ Post-heart surgery
☐ Other major medical conditions (e.g., diabetes, thyroid disease) _____
☐ Significant mental health conditions _____
☐ Attention Deficit Hyperactivity Disorder ☐ Learning Disability
☐ Other neurodevelopmental disorder (e.g., Asperger's, intellectual disability, fetal alcohol syndrome)
☐ Other _____

Any prior evaluations? ☐ No ☐ Yes When and what type? _____

Primary complaints or problems: _____
_____
_____

OTHER PROVIDERS / INVOLVED PARTIES

Family Doctor ☐ N/A Name: _____
Address / Phone:_____

Pediatrician ☐ N/A Name: _____
Address / Phone:_____

Neurologist ☐ N/A Name: _____
Address / Phone:_____

Psychiatrist ☐ N/A Name: _____
Address / Phone:_____

Psychologist or Clinical Counselor
☐ N/A Name: _____
Address / Phone:_____

Social Worker ☐ N/A Name: _____
Address / Phone:_____

Agencies ☐ N/A Name: _____
Address /Phone:_____

Name: _____
Address / Phone:_____

Attorney ☐ N/A Name: _____
Address /Phone:_____

Hospitals recently treated at: _____
_____
_____

OTHER INFORMATION OR COMMENTS

_____
_____
_____
_____
_____
_____
_____
_____