Centre intégré universitaire de santé et de services sociaux de l'Ouest-de-l'Île-de-Montréal

Québec

REFERRAL FORM – Cognitive Health Clinic

Send form by :

Fax	**(514) 888-4451**
Email	**clinique.sante.cognitive.comtl@ssss.gouv.qc.ca**

COMPLETE NAME OF PATIENT:
ADDRESS:
PHONE NUMBER:
HEALTH INSURANCE NUMBER:
DATE OF BIRTH:
CONTACT NAME (Name, relationship, address and phone number):
EMAIL ADDRESS (important for the first contact):

MMSE _____ /30 Date: _____ *If available: MoCA _____/30 Date: _____
☐ Please confirm that the patient doesn't have important cognitive complaints
Reason for referral :

Name, medical specialty and license number of referring physician (in block letters):

Date : Signature :