Mercer's Institute for Successful Ageing

Memory Clinic Referral Form

Date of referral: dd / mm / yyyy

Patient name: ---------- Date of Birth: dd / mm / yyyy

Address: ----------

Telephone [patient]: ----------

Telephone [next of kin]: ----------

Reason(s) for referral: ----------

Medical History: ----------

Psychiatric History: ----------

Medications:

(1) ---------- (6) ----------

(2) ---------- (7) ----------

(3) ---------- (8) ----------

(4) ---------- (9) ----------

(5) ---------- (10) ----------

Occupation [or, if retired, former occupation]: ----------

Education: Primary ☐ Secondary ☐ Third-level ☐

Alcohol [units per week]: ----------

Social circumstances: ----------

Mini-Mental State Exam score [MMSE]: ------ / ------

A brief cognitive assessment **is necessary** for this referral to be triaged appropriately.
Please include a copy of the completed MMSE with this referral form.

Has the patient's cognition / function been assessed by any other health care professional?

Yes ☐ No ☐

If **yes**, please include copies of previous reports with this referral form.

Has the patient had a previous **CT** / **MRI Brain**?

Yes ☐ No ☐

If **yes**, please state where the scan was carried out and please include a copy of the report if available. ----------

Does the patient have any contraindications to MRI imaging?

Yes ☐ No ☐

[eg: pacemaker or implantable defibrillator *in situ*, cardiac valve replacement, claustrophobia or metallic implants of any variety including aneurysm clips, cochlear implants, prosthetics or ocular metallic fragments in metalworkers]

Referral Source Details

Name: ----------

Address: ----------

Telephone: ----------

Mobile: ----------

The Memory Clinic

MISA Building, St James's Hospital, James's Street, Dublin 8

Telephone (01) 416 2640; Fax (01) 410 3487