



Mini-mental state exam score (MMSE): _____ / _____

A brief cognitive assessment **is necessary** for this referral to be triaged appropriately.
Please attach copy of completed MMSE to this letter.

Has the patient's cognition/function been assessed by: Name of clinician:

Medicine for the Elderly Yes ☐ No ☐ _____

Neurology Yes ☐ No ☐ _____

Psychiatry Yes ☐ No ☐ _____

Occupational Therapy Yes ☐ No ☐ _____

If YES to any of the above, please include copies of previous reports with referral.

Has the patient had a previous CT/MRI Brain? Yes ☐ No ☐

Please attach copy of report if available.

Does the patient have any contraindications to MRI imaging? Yes ☐ No ☐

(e.g. 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 number:

Mobile:

The information on this form is required for efficient triage and appropriate assessment.
Many thanks for your co-operation.

The Memory Clinic, Top Floor, Hospital 4, St James's Hospital, Dublin 8.

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