Providence Health Care

OLDER ADULT PROGRAM
EARLY INTERVENTION MEMORY CLINIC
REFERRAL / SELF - REFERRAL FORM

* 1 1 8 4 7 *

Referral Other

Place Patient Label Here

The Early Intervention Memory Clinic provides assessment and intervention for people aged 60 and older who live in the Vancouver Coastal Health Region and have experienced a change in their memory or thinking in the past 1 to 2 years. The clinic supports people to optimize brain health and maintain quality of life by reducing risks and developing beneficial lifestyle habits. **Please note: This clinic is not suited to those with longstanding cognitive difficulties** (see Health History below for examples). If cognitive changes have occurred 2 or more years ago, referral to SPH/MSJ Older Adult Outpatient Clinics suggested ****Please review referral guide on page 3 before referring to ensure criteria met****

PLEASE COMPLETE THIS FORM AND FAX TO (604-806-8390), MAIL, OR DROP OFF: Attention: Early Intervention Memory Clinic, 9B St. Paul's Hospital, 1081 Burrard Street, Vancouver BC, V6Z 1Y6

PART 1 – To be completed by client or by referral source with client (Note to MD/NP: work-up optional)

Referral Source: ☐ Self-referral ☐ Family Physician or Nurse Practitioner: _____
☐ Other: _____

Person being referred: First name:	Last name:	
Personal Health Number (PHN):	DOB: (dd/mmm/yyyy)	
Primary Language: _____ Interpreter required: ☐ Yes ☐ No		
Phone:	Is it ok to leave a message: ☐ Yes ☐ No	Alternate phone:
Can we contact you by email: ☐ Yes ☐ No If yes, email address:		
Name of Family Physician or Nurse Practitioner: ☐ see referral source		
How did you learn about the Early Intervention Memory Clinic?		
Reason for referral: (What are your main concerns about your memory or thinking? What are your hopes for the program?)		

PART 2 – Consent – To be completed by client

☐ I consent to be contacted for a 15-minute introductory phone call.

☐ If it is determined that I would benefit from meeting with a specialist physician (geriatrician), I consent to a referral being requested from my Family Physician or Nurse Practitioner.

☐ I consent to the Early Intervention Memory Clinic team sharing information with my Family Physician or Nurse Practitioner.

Client Signature: _____Date: (dd/mmm/yyyy) _____

PART 3 – Health History – To be completed by client or referral source.

HEALTH HISTORY: ☐ attached ☐ high blood pressure ☐ diabetes ☐ high cholesterol ☐ stroke/"mini stroke"/ TIA (transient ischemic attack) ☐ depression/anxiety ☐ hearing loss I have a longstanding medical condition that has affected my memory and thinking for many years (e.g., head injury/acquired brain injury, stroke, dementia) ☐ No ☐ Yes, please describe:	Other past and ongoing physical or mental health challenges. Please describe:	MEDICATION LIST:

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Your answers to this questionnaire will be used to assist the clinic team to better understand your needs so that we may offer services that will be most helpful to you.

Please choose the best answer for the statements below.

PART 4 – Screening Questionnaire – To be completed by client.				
1	I want to be proactive and learn more about how to keep my brain/mind healthy.	☐ Yes		☐ No
2	I have a family history of dementia, and this concerns me	☐ Yes		☐ No
3	I am feeling stressed, worried or down about my memory and thinking	☐ Yes, a lot	☐ Yes, a little	☐ No
4	My family or friends have told me they have noticed a change in my memory or thinking.	☐ Yes, a lot	☐ Yes, a little	☐ No
5	I am having difficulty with my short-term memory (e.g., recalling conversations or events, misplacing items, missing appointments, repeating questions).	☐ Yes, a lot	☐ Yes, a little	☐ No
6	I am having difficulty staying focused on a task or conversation.	☐ Yes, a lot	☐ Yes, a little	☐ No
7	I am having difficulty multi-tasking/doing more than one thing at a time.	☐ Yes, a lot	☐ Yes, a little	☐ No
8	I am having difficulty finding the words to say during conversation.	☐ Yes, a lot	☐ Yes, a little	☐ No
9	I have gotten lost or been disoriented in the community.	☐ Yes, a lot	☐ Yes, a little	☐ No
10	**What would be a meaningful outcome after involvement with the Early Intervention Memory Clinic? What matters most to you?** _____ _____ _____			
11	**Is there anything else you'd like to tell us at this time?** _____ _____ _____			

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MD/NP Referral Guide: Which clinic is best for my patient?		
	SPH Early Intervention Memory Clinic (EIMC)	**SPH/MSJ Older Adult Outpatient Clinics (OAC)**
REFERRAL	Self-referral from person with cognitive concerns or MD/NP referrals accepted. MD/NP referral requested by EIMC when specialist/geriatrician involvement indicated.	MD/NP referral required. EIMC referrals needing more comprehensive assessment will be transferred to OAC and MD/NP referral sign-off requested if needed. Scan QR code for OAC referral form and fax
CRITERIA	60 years and older living in the Vancouver Coastal Health Region.	Generally, 65 years and older living in the Vancouver Coastal Health Region. People less than 65 may be accepted on a case-by-case basis if neurodegenerative condition suspected.
	Cognitive changes within 1 to 2 years.	Cognitive changes may have occurred greater than 2 years ago.
	No cognitive diagnosis.	May have previous diagnosis of mild cognitive impairment (MCI) or dementia.
	No known causes of cognitive change (e.g., CVA).	May have other medical conditions that have contributed to cognitive changes.
	Has insight into cognitive changes.	May have limited insight into cognitive changes.
	Able and motivated to engage in self-management.	May require more support to make lifestyle changes or may struggle to engage in change.
SERVICES	Initial functional and cognitive assessment by an occupational therapist, with risk factor review and triage to geriatrician for targeted assessment as indicated.	Comprehensive geriatrician assessment and referrals to Older Adult outpatient allied team as appropriate.
	Geriatrician recommendations to MD/NP for medical follow-up as indicated.	Follow-up with geriatrician and allied team as indicated.
	Follow-up with occupational therapist for cognitive strategies and brain health habits. **and/or**	Group or individual follow-up with allied team as indicated.
	Online or in-person brain health education and behaviour change groups for person with cognitive change and care partner.	MCI care partner group offered or referral to Dementia Caregiver Resilience Clinic as appropriate.