

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


* 1 1 8 4 7 *

Referral Other

The Early Intervention Memory Clinic provides assessment and intervention for **people aged 60 and older who live in the Vancouver area 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 (see referral guide on page 3).

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 referral source. | | |
|--|---|--|
| Referral Source: <input type="checkbox"/> Self-referral <input type="checkbox"/> Family Physician or Nurse Practitioner: _____ | | |
| <input type="checkbox"/> Other: _____ | | |
| Person being referred: First name: | Last name: | |
| Personal Health Number (PHN): | DOB: (dd/mmm/yyyy) | |
| Primary Language: _____ | | Interpreter required: <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Phone: _____ | Is it ok to leave a message: <input type="checkbox"/> Yes <input type="checkbox"/> No | Alternate phone: _____ |
| Can we contact you by email: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, email address: _____ | | |
| Name of Family Physician or Nurse Practitioner: _____ | | <input type="checkbox"/> 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 | | |
| <input type="checkbox"/> I consent to be contacted for a 15 minute introductory phone call. | | |
| <input type="checkbox"/> 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. | | |
| <input type="checkbox"/> 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: <input type="checkbox"/> attached <input type="checkbox"/> high blood pressure <input type="checkbox"/> diabetes <input type="checkbox"/> high cholesterol <input type="checkbox"/> stroke/"mini stroke"/ TIA (transient ischemic attack) <input type="checkbox"/> depression/anxiety <input type="checkbox"/> 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) <input type="checkbox"/> No <input type="checkbox"/> Yes, please describe: | Other past and ongoing physical or mental health challenges. Please describe: | MEDICATION LIST: |
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Place Patient Label Here



Referral Other

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. | <input type="checkbox"/> Yes | | <input type="checkbox"/> No |
| 2 | I am feeling stressed, worried or down about my memory and thinking. | <input type="checkbox"/> Yes, a lot | <input type="checkbox"/> Yes, a little | <input type="checkbox"/> No |
| 3 | I have a family history of dementia, and this concerns me. | <input type="checkbox"/> Yes | | <input type="checkbox"/> No |
| 4 | My family or friends have told me they have noticed a change in my memory or thinking. | <input type="checkbox"/> Yes | | <input type="checkbox"/> No |
| 5 | I am having difficulty with my short-term memory (e.g., recalling conversations or events, misplacing items, missing appointments, repeating questions). | <input type="checkbox"/> Yes, a lot | <input type="checkbox"/> Yes, a little | <input type="checkbox"/> No |
| 6 | I am having difficulty staying focused on a task or conversation. | <input type="checkbox"/> Yes, a lot | <input type="checkbox"/> Yes, a little | <input type="checkbox"/> No |
| 7 | I am having difficulty multi-tasking/doing more than one thing at a time. | <input type="checkbox"/> Yes, a lot | <input type="checkbox"/> Yes, a little | <input type="checkbox"/> No |
| 8 | I am having difficulty finding the words to say during conversation. | <input type="checkbox"/> Yes, a lot | <input type="checkbox"/> Yes, a little | <input type="checkbox"/> No |
| 9 | I have gotten lost or been disoriented in the community. | <input type="checkbox"/> Yes, a lot | <input type="checkbox"/> Yes, a little | <input type="checkbox"/> No |
| 10 | <p>What would be a meaningful outcome after involvement with the Early Intervention Memory Clinic? What matters most to you?</p> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> | | | |

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Referral Other

| MD/NP Referral Guide: Which clinic is best for my patient? | | |
|--|---|---|
| | SPH Early Intervention Memory Clinic (EIMC) | SPH/MSJ Older Adult Outpatient Clinics |
| R E F E R R A L | <p>Self-referral from person with cognitive concerns or MD/NP referrals accepted.</p> <p>MD/NP referral requested by EIMC when specialist/geriatrician involvement indicated.</p> | MD/NP referral required. |
| C R I T E R I A | <p>60 years and older.</p> <p>Cognitive changes within 1 to 2 years.</p> <p>No cognitive diagnosis.</p> <p>No known causes of cognitive change (e.g., CVA).</p> <p>Has insight into cognitive changes.</p> <p>Able and motivated to engage in self-management.</p> | <p>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.</p> <p>Cognitive changes may have occurred greater than 2 years ago.</p> <p>May have previous diagnosis of mild cognitive impairment (MCI) or dementia.</p> <p>May have other medical conditions that have contributed to cognitive changes.</p> <p>May have limited insight into cognitive changes.</p> <p>May require more support to make lifestyle changes or may struggle to engage in change.</p> |
| S E R V I C E S | <p>Initial functional and cognitive assessment by an occupational therapist, with risk factor review and triage to geriatrician for targeted assessment as indicated.</p> <p>Geriatrician recommendations to MD/NP for medical follow-up as indicated.</p> <p>Follow-up with occupational therapist for cognitive strategies and brain health habits.</p> <p>and/or</p> <p>Online or in-person brain health education and behaviour change groups for person with cognitive change and care partner.</p> | <p>Comprehensive geriatrician assessment and referrals to Older Adult outpatient allied team as appropriate.</p> <p>Follow-up with geriatrician and allied team as indicated.</p> <p>Group or individual follow-up with allied team as indicated.</p> <p>MCI care partner group offered or referral to Dementia Caregiver Resilience Clinic as appropriate.</p> |