UNIVERSITY OF SASKATCHEWAN

RURAL AND REMOTE MEMORY CLINIC

Patient Referral Information

Patient Name: _____

    Patient Contact Info:

        Address:_____

        Phone Number: _____(home) _____(cell)

    Patient DOB: _____

    Patient SHSP#: _____

    Patient's Next of Kin:

        Name: _____

        Phone Number: _____(home) _____(cell)

Referral Source: Name:_____ Clinic:_____

        Phone Number:_____ Fax Number:_____

Patient Reason for Referral (please provide as much detail as possible so that we can determine the best assessment pathway):

Patient Health History including testing completed to date:

Please fax the completed form to 306-966-1152 (c/o RRMC)

For more information please visit our website: www.remote**memory**clinic.ca

This form is as updated **August, 2020**. Regularly check our website to ensure you have most up-to-date version.