Avicenna Centre for Brain Health Referral
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Calgary, AB
T3B 0L4
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E.mail: info@avicennabrainhealth.com

First Name:	**Last Name:**	
Pt ULI:	**DOB (m/d/y):**	
Address:		
Phone (Cell):	**Phone (Home):**	
Next Of Kin:	**Relationship:**	**Phone:**
Consent To Consult (Patient or NOK)? ☐ **Y** ☐ **N**	**Extended Health Coverage?** ☐ **Y** ☐ **N**	
Consent to Review Health Authority Records? ☐ **Y** ☐ **N**		

GP/NP INFORMATION

GP/NP:	**Billing Number:**
Telephone:	**Fax:**

Reason for Referral (Presenting Problems & Expected Outcome):

Medical Conditions & Surgeries:

Current Medications:

Allergies:

Current / Previous Psychiatric History:

Identified risk:	Concern	Identified risk	Concern	Identified Risk:	Concern
Health issues	☐	Recent loss of loved one	☐	Alcohol / substance use	☐
Cognitive changes	☐	Recent stressful event	☐	Driving concerns	☐
Aggression (physical / verbal)	☐	Self-neglect	☐	Financial abuse	☐
Behavioral changes	☐	Mood changes	☐	Physical abuse	☐
Suspiciousness / paranoia	☐	Suicidal thoughts	☐	Homeless or at risk	☐
Wandering	☐	Disturbed sleep	☐	Falls / Gait disorder	☐
Client lives alone	☐	Appetite changes	☐	Freq hospitalizations	☐
Firearm / Weapons / gun	☐	Caregiver stress	☐	Other	☐