Groote Schuur Hospital MEMORY CLINIC: REFERRAL FORM

Patient name **Relative/carer name**	**Contact telephone** **Address**

Referring clinic	**Referring doctor**

Contact number	**Fax Number**

Reason for referral

Medical history	**Psychiatric history**

Current treatment

Special investigations

MMSE	Other
HB	
TSH	
U&E	

***Please fax referral to Ms Sonya Hendricks: 021 406 6846.**
For enquiries, please contact 021 404 2119 **