

Cognitive Assessment Referral Form

I hereby request that the Alzheimer Society Haldimand Norfolk complete a Cognitive Assessment consisting of a MOCA, MMSE, Clock Draw test and Executive Function test for:

Name: _____

Address: _____

Tel #: _____

DOB: _____

Health Card #: _____

Please choose who you would like us to contact to set up an appointment

Contact the **person getting tested** Contact the **person below**

Name: _____ Relationship to person: _____

Contact phone number: _____

And return the results to my office:

Physician name: _____

Address: _____

Fax #: _____

Phone #: _____

Signature: _____

Date: _____

**Please fax to Kathie Poitras
519-428-2968**

Please be advised that Kathie Poitras, RPN, PRC will be completing a written assessment, along with the cognitive assessment to your office. This assessment will include information pertaining to assessing whether your patient may be a 'medically at-risk driver'.