PEEL MEMORY AND COGNITIVE
DISORDERS CLINIC

DR. DAVID DUNCAN & DR. LAWRENCE FREEDMAN

CLINICAL NEUROPSYCHOLOGISTS

Referral Form

Client name: ____ □ **M** □ **F**

Address: ____

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Phone # ____________________________ **DOB**: ________________________

Referral for: □ **Dr. Duncan** □ **Dr. Freedman** □ **No preference**

Reason for Referral: ____

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Current Medications: ____

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Completed investigations: □ **Blood work** □ **Neuroimaging (CT/MRI)**
□ **EEG** □ **Neurological Consult**
□ **Other:** __________________________________
(Please provide copies of any reports or consult notes)

Referring MD: ____

Address: ____

Phone # ________________________ **Fax #** ______________________________

Send referral to:
Peel Memory & Cognitive Disorders Clinic
101 Queensway West, Suite 304 Mississauga, ON L5B 2P7
TEL: 905-272-1015 FAX: 905-803-9597

Please note:
After receiving this referral we will contact your patient directly.