PRISMA HEALTH℠

Patient's Name: _____ DOB: _____
SSN: _____-_____-_____ Address: _____

1st Contact Person: _____ Relationship: _____
Home Phone: _____Cell Phone: _____

2nd Contact Person: _____ Relationship: _____
Home Phone: _____ Cell Phone: _____

Referring Physician: _____ Phone: _____ Fax: _____
Primary Care Physician: _____ Phone: _____ Fax: _____

Person Sending Referral: _____ Date Sent: _____

MEMORY HEALTH EVALUATION
To better prepare for the evaluation, please indicate areas of concern (check all that apply):

Diagnosis:
- ☐ Memory Loss/ Cognitive Deficits
- ☐ Mild Cognitive Impairment
- ☐ Dementia

Identified Resources that are needed:
- ☐ Inadequate Social Support
- ☐ Behavioral Issues
- ☐ Caregiver Stress
- ☐ Resource Needs (Financial Concerns/ Advanced Care Planning, etc.)

☐ Evaluate & Treat OR ☐ Evaluate & Recommend

PLEASE SEND THE FOLLOWING INFORMATION TO OUR OFFICE:
- ☐ Completed Referral Form
- ☐ Copy of all insurance cards
- ☐ All office notes related to reason for referral (must include memory health concern.)
- ☐ Complete Medication List
- ☐ Brain imaging performed since deficit noted: CT or MRI (not required, but helpful)
- ☐ Most recent results of the following labs: B12, TSH, RPR, CMP, CBC, MMA (not required, but helpful.)

*** We will schedule appointment with patient or Caregiver & notify the referring MD and PCP. ***

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