



Memory Assessment and Research Services

Fax Referral Form

Fax completed form to (910) 962-2478

Provider requesting referral: _____ Phone: _____ Fax: _____
 Office Contact (Receptionist/Nurse): _____ Date of Next Office Visit _____
 Expedite Test Results: Yes (2 - 3 weeks) _____ No (3 - 4 weeks) _____
 Suspected Diagnosis: Memory Loss _____ Dementia _____ Cognitive Disorder _____
 Differential Diagnosis from Mood Disorder _____ Other _____

Patient: _____ DOB: _____ Phone: (H) _____ (W or C) _____
 Address: _____
 Patient Contact (if applicable): _____ Phone: (H) _____ (W or C) _____
 Primary Insurance: _____ Subscriber ID# _____ Group # _____
 Preauthorization #: 1-800 _____ - _____
 Secondary Insurance: _____ Subscriber ID# _____ Group# _____
 Preauthorization #: 1-800 _____ - _____

Select appropriate assessment option (check one):

- 1. **Diagnostic Evaluation:** 4 to 5-hour appointment (this evaluation can be conducted over two sessions). The patient **has not** been previously diagnosed with a memory disorder or there is a question regarding the diagnosis. This evaluation determines diagnosis.
- 2. **Optimizing Treatment:** 2 to 2.5-hour appointment. The patient **has** already been diagnosed with a memory disorder and is currently on medication. This evaluation assesses the effectiveness of treatment.
- 3. **Counseling:** Multi-session intervention that focuses on supporting, preparing, and educating the client and/or caregiver on ways to cope with stressors secondary to a diagnosis of memory loss.

Please send a list of current medications including start/stop dates and dosages of all psychotropic and memory medications, as well as relevant medical records (e.g., MRI, neurological and/or neuropsychological records).