THE MEDICAL ARTS HEALTH RESEARCH GROUP
a division of PCT Networks Inc.

MEMORY CLINIC PATIENT REFERRAL FORM

DATE _____ (mm/dd/yyyy)

PATIENT NAME _____

DOB (MM/DD/YYYY) _____

PHONE _____

CITY/TOWN _____

REFERRING PHYSICIAN _____

CLINIC PHONE / FAX _____

PHYSICIAN EMAIL _____

PLEASE 'X' COGNITIVE TESTS TO BE COMPLETED

MMSE	
CLOCK DRAWING	
VERBAL AND EXECUTIVE FUNCTIONING	
TRAIL MAKING TEST PART A	
TRAIL MAKING TEST PART B	
MOCA	
FUNCTIONAL ACTIVITIES QUESTIONNAIRE	

HAS THE PATIENT BEEN NOTIFIED OF THIS REFERRAL ? YES / NO

WILL A CAREGIVER BE ACCOMPANYING THE PATIENT TO THE CLINIC (PREFERABLE) ? YES / NO

CAREGIVER'S NAME AND RELATIONSHIP : _____

PATIENT DIAGNOSIS / SYMPTOMS / MED HX / ALLERGIES : _____

PLEASE FAX COMPLETED FORM TO: 1 855.318.2221

QUESTIONS? PLEASE CALL 1.888.570.8885

- Memory clinic fee is $45 per patient (if there is hardship the fee will be waivered)
- One day per month the memory clinic will be offered at no charge to a maximum of 6 patients that day