SUNY Downstate Medical Center

Center of Excellence for Alzheimer's Disease *(CEAD)*
Downstate Medical Center

Evaluations are available for New & Continuing patients

COMPREHENSIVE MEMORY EVALUATION REFERRAL FORM

Patient Name: _____ Date: _____

Sex: _____ Date of Birth: _____

Insurance Carrier: _____ Insurance ID#: _____

Home Phone: _____ Cell Phone: _____

RELEVANT CLINICAL HISTORY:
(If Available, Attach Recent Labs, EKG, Neuroimaging)

SYMPTOMS TO BE EVALUATED (Select All That Apply):

- ❑ Memory
- ❑ Functional Decline
- ❑ Depression
- ❑ Anxiety
- ❑ Hallucinations/Delusions
- ❑ Wandering
- ❑ Agitation / Aggression
- ❑ Sleep Disturbances
- ❑ Caregiver Stress
- ❑ Other (SPECIFY):

REQUESTED SERVICES (Select All That Apply):

- ❑ Comprehensive Dementia Evaluation
- ❑ Treatment for Memory Deficits
- ❑ Community Service Referral(s)
- ❑ Treatment for Behavioral/Psychiatric Symptoms
- ❑ Caregiver Support and Information
- ❑ Other (SPECIFY):

REFERRING PROVIDER INFORMATION:

Provider Name: _____ Specialty: _____

Signature: _____ Phone #: _____

Fax #: _____ Address: _____

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