SUNY DOWNSTATE Health Sciences University

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

SUNY Downstate Health Sciences University

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: _____

Center of Excellence for Alzheimer's Disease (CEAD) *(Formerly Brooklyn ADAC)*
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