Memory and Aging Center Clinic
Department of Neurology, Box 3017
1500 Owens Street Suite 320 | San Francisco, CA 94143
memory.ucsf.edu
tel: 415.353.2057 | fax: 415.353.8292

UCSF Weill Institute for Neurosciences
Memory and Aging Center

REFERRAL FORM

Thank you for choosing to refer your patient to us. To start the referral process, please fax this form and one year of medical records, lab work, MRI results to our office at 415.353.8292. For additional information, visit our website at memory.ucsf.edu/make-referral.

Date: ______________________

Name of patient: ______________________ Date of birth: ______________

Home address: ______________________

Home phone: ____________ Cell phone: ____________ Work phone: ____________

Language: ______________________ Interpreter needed: Yes No

Name of primary contact person involved in care (for example, a family member): ______________

Address: ______________________

Home phone: ____________ Cell phone: ____________ Work phone: ____________

Insurance information (include copies of patient insurance, both sides): ______________

Referring MD: ______________________ Specialty: ______________

Phone: ______________ Fax: ______________

PCP name: ______________________

Phone: ______________ Fax: ______________

Are you referring to a particular physician? Yes No If yes, MD name ______________

Referral Reason/s for Consultation (include one year of medical records, lab work, MRI results)

Suspected degenerative disease? Yes No If yes, diagnosis: ______________

Is patient aware of diagnosis? Yes No Second opinion? Yes No

Established diagnosis/social support? Yes No Are they looking to establish care? Yes No

Clinical question to be answered: ______________

Patient/family goals for visit: ______________

Neuropsychological testing only? Yes No

Testing done? MMSE: Yes No Score: ________ MOCA: Yes No Score: ________

Neuropsychological testing (include copy of all test results)? Yes No Date: ______________

Traumatic brain injury (TBI) or concussion? Yes No If yes, when was TBI/concussion? ______________

Assessment prior to surgery? Yes No If yes, type? ______ Scheduled? Yes No If yes, when? ______

Does the patient have active cancer? Yes No When did treatment start? ______________

Genetic counseling only? Yes No Suspected diagnosis or family history? ______________

Does your patient have any special needs that we need to be made aware of? ______________