Memory and Aging Center Clinic
UCSF Department of Neurology
Memory and Aging Center, Box 3017
1651 4th St, Suite 212 | 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 the UCSF Memory and Aging Center Clinic. To start the referral process, please fax this form and one year of medical records, lab work, and copy of both sides of your insurance card to our office at 415.353.8292 and mail a copy of your MRI scan to the address above. For additional information, visit our website at memory.ucsf.edu/services/gateway/make-referral.

Date: _____

Name of patient: _____ Date of birth: _____

Home address: _____

Home phone: _____ Cell phone: _____

Primary language: _____ Interpreter needed: ☐ Yes ☐ No

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

Address: _____

Home phone: _____ Cell phone: _____

Insurance carrier, PPO/HMO, and subscriber number: _____

Referring MD: _____ Specialty: _____

Phone: _____ Fax: _____

PCP name: _____

Phone: _____ Fax: _____

Reason for Referral

URGENT? (prion disease, rapidly progressive dementia or encephalitis?) ☐ Yes ☐ No

Clinical question to be answered, please be specific: _____

_____

Records (include one year of medical records, lab work and MRI results)

Has the patient completed neuropsychology testing prior to referral? ☐ Yes ☐ No
(If yes, please include report)

Has the patient had brain imaging within the last 2 years? ☐ Yes ☐ No **Please mail disc or push to Life Image**

Insurance authorization complete? ☐ Yes ☐ No

An appointment will not be scheduled without authorization. Please refer to our referral checklist for codes required.