## FAX REFERRAL FORM

<table>
<thead>
<tr>
<th>Patient:</th>
<th>Telephone:</th>
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<tbody>
<tr>
<td>Physician:</td>
<td>Preferred Contact:</td>
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<tr>
<td></td>
<td>(if other than Patient)</td>
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</tbody>
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Please check those services that you are requesting the MWC perform for your patient

### Comprehensive Memory/Cognitive Evaluation

The Comprehensive Memory Evaluation includes a Dementia-Specific History and Physical, Functional, Emotional, and Family Needs Assessment, Neuropsychological Assessment, Case Conference, and Family/Patient Feedback Session.

All findings and recommendations are sent to the referring physician for continuation of care. As part of the evaluation we request that laboratory studies and neuroimaging studies be performed in compliance with the NINCDS-ADRDA standards.

**Laboratory (Including thyroid Panel, B12 and Folate):** Please choose one option
- ___ Labs to be drawn by referring physician and forwarded to the MWC.
- ___ Labs to be drawn by MWC and results forwarded to referring physician.

**Neuroimaging:** Please choose one option
- ___ Neuroimaging to be ordered by referring physician and forwarded to MWC.
- ___ Neuroimaging to be ordered by MWC and forwarded to referring physician.

___ Yes, provide information re: potential pharmaceutical trials to discuss with referring physician
___ No, do not provide information re: pharmaceutical trials

### Additional Services: (Please refer to our brochure or visit our website for more information)

- ___ Day Center – full and half day options for persons with mild and moderate dementia
- ___ Driver Assessment Program
- ___ Neuropsychological Evaluation only
- ___ Patient and/or Family Counseling, Education and Support

**Additional comments:**

___________________________________________________________________________________________

**PLEASE SIGN AND FAX FORM TO THE MWC @ 561-297-0505**

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<tr>
<th>Physician Signature:</th>
<th>Date:</th>
<th>Fax #:</th>
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