

Referral Request:

Thanks for partnering with Georgia Memory Net. We're dedicated to providing your patients with an accurate diagnosis, and then returning them to your capable care. If you have any questions about this referral, call us at 706-571-1120.

Date of Referral: _____

Georgia Resident

Patient:

Last Name: _____

First Name: _____

MI: _____ DOB: _____

Gender: M / F (circle one)

Marital Status: _____

Home Phone: _____

Mobile Phone: _____

Email: _____

Address: _____

City: _____

State: _____

Zip: _____

Country: _____

Primary Language: _____

Interpreter required? N / Y (circle one)

Type: _____

Family Caregiver/Emergency Contact:

Name: _____

Preferred Phone: _____

Email: _____

Patient Insurance:

Insurance Carrier: _____

Member ID: _____

Group Number: _____

Copy of Insurance Card Attached

Referring Provider:

Referring Provider Name: _____

Provider NPI Number: _____

Address: _____

City: _____

State: _____

Zip: _____

Phone: _____

Fax: _____

Email: _____



Please include the following:

- Annual Wellness Visit notes including which Cognitive Screening Tool used and outcomes

If available, please also include the following:

- Recent labs (within past year) including comprehensive metabolic, CBC, B12 level, TSH, Lipid panel, HgbA1c, RPR
- List of current medications
- Problem list
- Allergies
- Relevant clinical notes
- Brain MRI (or CT if patient has pacemaker, mechanical heart valve/stents or previous injury involving metallic object) within the past year

Please fax these documents, along with completed referral form to:

Fax: 706-571-1603

Attn: Scheduling Coordinator

Georgia Memory Net

Memory Assessment Clinic

at Piedmont Columbus Regional Family Medicine Center

1800 10th Avenue

Columbus, GA 31901