

## 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:

#### Columbus

Phone: 706-571-1120

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