Referral Form - Broadlawns Memory Clinic

T: 515-282-5700 F: 515-282-5705

1801 Hickman Road
Des Moines, IA 50314

PATIENT INFORMATION

Patient Name: _____ DOB: / /

Male☐ Female☐ Phone Number: _____

Alternate Contact Name & Phone Number _____

Street Address: _____ City/State/Zip: _____

☐Interpreter Needed Language _____

MEMORY CONCERNS (Please Share Memory Concerns Below)

REASON FOR REFERRAL- Please Check All That Apply

☐Diagnostic Evaluation ☐Treatment Recommendations

☐Infusion (Anti-Amyloid Infusion) ☐GUIDE (Guiding an Improved Dementia Experience)

☐Behavioral or Psychiatric complications related to memory changes ☐Other _____

Please include the following information as part of the referral:

- Medical/Psychiatric/Surgical History
- Medication List
- Recent Lab Work including B12, CBC, CMP, TSH, homocysteine level, and c-reactive protein (CRP) Alzheimer's Blood biomarker (if available)
- Recent Brain imaging CT, MRI, PET (if available)
- Results of other related tests of consultations

REFERRING PROVIDER/GROUP

Referring Facility: _____ Referring Phone Number: _____

Referring Provider: _____ NPI# _____

Fax Number: _____

REQUIRED INFORMATION

Copy of Insurance Cards Insurance Carrier: _____ Member ID: _____

Insurance Authorization # (if applicable) _____

Please note that this a referral to the Memory Clinic, and we cannot guarantee which provider will see the patient. Appointments are scheduled with the provider best suited to the patient's needs.

Referrals may require additional phone calls if required information is not included.