Division of Geriatric Medicine
Center for Success in Aging
Memory Health Program Referral Form

255 Enterprise Blvd, Suite 101
Greenville, SC 29615
Ph: 864-454-8120 Fax: 864-454-8125

Patient's Name: _____ DOB: _____
SSN: _____-____-_____ Address: _____

1st Contact Person:_____ Relationship: _____
Home Phone: _____ Cell Phone: _____

2nd Contact Person: _____ Relationship: _____
Home Phone: _____ Cell Phone: _____

Referring Physician: _____ Ph:_____ Fx: _____
Primary Care Physician: _____ Ph: _____ Fx: _____

Person Sending Referral: _____ Date Sent: _____

Memory Health Evaluation

To better prepare for the evaluation, please indicate areas of concern (check all that apply):

- ☐ Mild Cognitive Impairment
- ☐ Dementia/ Memory Loss
  - ☐ Inadequate social support
  - ☐ Behavioral Issues
  - ☐ Care Planning/Advanced Directive
  - ☐ Placement assistance/level of care
  - ☐ Caregiver stress
  - ☐ Financial concerns/limited resources

☐ Evaluate and Treat **OR** ☐ Evaluate and Recommend

Please send the following information to our office:

- ☐ Completed referral form
- ☐ Copy of insurance cards
- ☐ All office notes related to reason for referral
- ☐ Complete Medication List
- ☐ Brain imaging performed since deficit noted: CT or MRI
- ☐ Most recent results of the following: B12, TSH, RPR, CMP, CBC, MMA

We will schedule the appointment and notify the referring MD and PCP