Duke Memory Clinic Referral Form

Please fax the completed referral form to 919-668-0374. This information will be reviewed and if appropriate, an initial video visit will be scheduled.

Your careful review of the form will help us ensure your patient is referred to the correct provider. Thank you.

Physician Information

Referring Physician: _____ Date of Referral: _____

Practice / Group Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Provider Phone: _____ Fax: _____

Patient Information

Patient Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Contact Phone Number: _____

Symptoms and Test Results

Is the patient's walking normal? Yes ☐ No ☐

Is the patient a significant Fall Risk? Yes ☐ No ☐

Can the patient be left alone for a day without issue ? Yes ☐ No ☐

Has the patient had a Brain MRI in the last 2 years? Yes ☐ No ☐

Include the score for any ONE of the following Cognitive Tests

MOCA Score:	26-30 ☐	17-25 ☐	16 or below ☐
Date:	less than 6 mo ☐	6 mo - 1 yr ☐	greater than 1 yr ☐
MMSE Score:	28-30 ☐	22-28 ☐	21 or below ☐
Date:	less than 6 mo ☐	6 mo - 1 yr ☐	greater than 1 yr ☐
SLUMS Score:	26-30 ☐	17-25 ☐	16 or below ☐
Date:	less than 6 mo ☐	6 mo - 1 yr ☐	greater than 1 yr ☐

Preliminary Diagnosis

Please check all that apply

- ☐ Normal cognition
- ☐ Subjective cognitive changes
- ☐ Mild cognitive impairment
- ☐ Mild dementia
- ☐ Moderate/severe dementia
- ☐ Alzheimer's disease
- ☐ Lewy body dementia
- ☐ Fronto-temporal dementia
- ☐ Vascular dementia due to multiple strokes

If desired, include additional information you want to share? _____

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DukeHealth