# Duke Neurology Memory Clinic Referral Form

**Please fax the completed referral form to 919-668-0374. 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