



# UCC Memory Clinic

730 W. Washington St, Milwaukee, WI 53204

Phone: (414) 649-2805

Fax: (414) 649-2824

## Diagnostic Consultation & Services Referral

*Please complete and fax or mail to address above:*

**Referral Information:**

**Referral Date** \_\_\_\_\_

Patient/Client Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Female \_\_\_ Male \_\_\_

Ethnicity/Race \_\_\_\_\_ Primary Language Spoken: Spanish \_\_\_ English \_\_\_ Other \_\_\_

1<sup>st</sup> Contact/Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

2<sup>nd</sup> Contact/Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

**Decision Maker:** *Self Guardian Applying for Guardianship Activated POA-H  
Has POA-H Has POA-F POA Info Offered*

POA Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship: \_\_\_\_\_

**Referral Reason(s):**

Why is patient/client being referred? Please check: *(Fill the comments space as needed)*

**Senior Center (Social model/Nutrition Site for Self-independent 60 Years** \_\_\_\_\_

**Adult Day Care Services Recommendation** \_\_\_\_\_ **Memory Evaluation** \_\_\_\_\_

**Explanation/ Comments:** \_\_\_\_\_

**Referring provider/ PCP information:**

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Clinic/hospital: \_\_\_\_\_ Fax: \_\_\_\_\_

Referring contact person (if different): \_\_\_\_\_ Phone: \_\_\_\_\_

Fax: \_\_\_\_\_ Email: \_\_\_\_\_ Organization: \_\_\_\_\_

**Please include the following information with the referral form:**

Current Diagnoses list, Current Medication list, Last MD visit note (if available), insurance information.

\_\_\_ Attached \_\_\_ Faxed \_\_\_ Mailed \_\_\_ Available upon request

**Appointment Confirmation Contact:**

Who do you wish contacted with appointment information? (Check all that apply).

\_\_\_ Patient \_\_\_ Patients Caregiver \_\_\_ Referring Agency

\_\_\_ Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

<b>Referring Provider Signature:</b>			<b>Date:</b>
<b>Received at UCC:</b>	<b>Staff:</b>	<b>Confirmed Receipt:</b>	<b>By: Phone/Fax/Email</b>



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