Hartford HealthCare
Ayer Neuroscience Institute

MEMORY CARE CENTER

New Patient Referral Form

Phone: (860) 545-7550 Fax (860) 545-7180

Thank you for considering the Memory Care Center for your patient. Please **complete this form in its entirety** to ensure timely response to your request, and be sure to attach a copy of the following information:

- ☐ Medical Problem List
- ☐ Active Medication List with allergies
- ☐ Most Recent Office Notes
- ☐ Neuroimaging (Brain MRI/PET/CT)
- ☐ Labs (B12, TSH/Free T4)
- ☐ Copy of Insurance card
- ☐ Cognitive screening tool (ie. SLUMS, MOCA, Mini-Cog, etc)

PATIENT NAME: _____ D.O.B._____

Age: ____ Patient Phone Number: _____ Preferred language: _____

Patient Address: _____

Family Contact Name: _____ Family Phone number: _____

Referring Physician Name: _____

Phone: _____ Fax : _____

Physician Address: _____

PCP Name_____ PCP Phone: _____

PCP Address: _____

Reason for referral: _____

_____

_____

_____

Please affirm the following criteria for intake:

- ☐ Psychiatrically stable (no acute depression, anxiety or psychosis)
- ☐ No acute mental status change
- ☐ Medically Stable
- ☐ No active substance abuse
- ☐ **The patient is aware of and consents to the referral**

Please indicate the best person to contact for intake scheduling _____

Office use only: Please check all that apply:

☐ Labs ☐ Neuroimaging ☐ Office Visit Notes ☐ Complete Reason for referral ☐ Med List