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Walker Memory Center Referral Form

Please fill this form out completely and fax this along with a face sheet, current medication list, most current Clinic note and any current CT or MRI report of the brain.

Referring Provider: _____ Clinic/Hospital: _____

Phone #: _____ Fax#: _____

Patient Name: _____ Patient DOB: _____

Contact name and number for scheduling: _____

Referring Diagnosis: _____

Is the patient currently taking any of the following medications? *Check all that apply*:

- ☐ Antipsychotics
- ☐ Benzodiazepines
- ☐ Opioids
- ☐ Skeletal Muscle Relaxants
- ☐ Tricyclic Antidepressants
- ☐ Hypnotics
- ☐ First-generation antihistamines

Are you seeking **Consultation** or **Management of Care**? Circle one.

Do not complete. This section is for the use of UAMS Walker Memory Center Staff.

Date referral Rec'd: _____

AR PMP results: _____

Scheduled: **Yes or No** If "No," why? _____