



Donald W. Reynolds
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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: _____

Service Requested (circle one): Memory Evaluation with MD or Neuropsychological Testing (Dr. Compton)

A Physician's ORDER is required for the NPT with Dr. Compton. Please send with referral.

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? _____