Neuropsychological and support services

MONTCLAIR MEMORY CLINIC

A pathway for individuals with memory loss concerns and their families

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PHYSICIAN REFERRAL FORM

REFERRING PROVIDER INFORMATION

Referring Physician: _____

Practice Name & Address: _____

Website/E-mail: _____ Phone: _____ Fax: _____

PATIENT INFORMATION

Name: _____

Address: _____

Date of Birth: _____

DIAGNOSTIC INFORMATION

Medical History

Diagnosis 1	
Diagnosis 2	
Diagnosis 3	

REFERRAL QUESTIONS

Additional Comments/Concerns:

Selection of Referral questions: Please select all questions that apply

☐	1. Does he/she have a neurocognitive impairment?
☐	2. Does this represent a change from a lifetime baseline?

☐	3. Does he/she meet the criteria for dementia?
☐	4. Is the pattern consistent with Alzheimer's Disease?
☐	5. Is the pattern consistent with Cardiovascular disease?
☐	6. Is the pattern consistent with Parkinson's Disease?
☐	7. Is the pattern consistent with other dementia?
☐	8. Is the pattern consistent with Primary Progressive Aphasia?
☐	9. Is the patient's presentation consistent with depression?
☐	10. Is there another explanation for cognitive impairment or changed behavior?
☐	11. Has the patient's presentation improved since his/her previous assessment?
☐	12. Has the patient's presentation improved since treatment?
☐	13. What is the patient's mental status prior to procedures such as surgery, Deep brain stimulation, Bariatric surgery, etc.? (Explain above if applicable)
☐	14. Is the patient able to follow medical recommendations and adhere to medical treatment?
☐	15. What lifestyle changes are recommended for the patient to maintain modified independence? (Explain above if applicable)

PREFERRED POINT OF PATIENT CONTACT:

Name of Contact: _____

Phone number: _____

Relationship: ☐ Patient ☐ Family ☐ Other

PLEASE ALSO INCLUDE:

~ Physician's script

~ Authorized referral if needed

~ Lab and Brain imaging reports

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Dr. Rondeau welcomes phone contact with physicians who may have additional questions or concerns.