



## Patient Referral Form

Thank you for choosing to refer your patient to us. To begin the referral process, please **fax** this completed form to the UNM Appointment Center at **(505) 272-9427**.

- Include pertinent medical records, including last PCP clinical note; lab results; and brain imaging.
- Include patient's insurance card(s) (both sides) and HMO authorization if required.
- For additional assistance, please call (505) 272-1754.

To: **Center for Memory & Aging**

**PATIENT INFORMATION:**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
(first name) (last name) (dd/mm/yyyy)

Address: \_\_\_\_\_  
(number) (street name) (unit)

\_\_\_\_\_ (city) (state) (postal code) (county)

\_\_\_\_\_ (phone) (alternate phone) (e-mail address)

Interpreter needed?:  Yes  No If yes, please indicate language: \_\_\_\_\_

**CONSULTATION REQUEST INFORMATION:**

Reason for Referral/Consultation: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Diagnosis/ICD10: \_\_\_\_\_

**REFERRING PHYSICIAN INFORMATION:**

Referring Provider: \_\_\_\_\_ Specialty: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

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

Practice Name: \_\_\_\_\_ Email: \_\_\_\_\_

Signature \_\_\_\_\_

NOTICE OF CONFIDENTIALITY: This is a confidential fax and is intended solely for the person indicated above. If you are not the intended person, you are hereby notified of the confidential nature of this fax and that you are not entitled to read, copy, or otherwise disseminate any of the information contained herein.