



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 any pertinent medical records, including test results and imaging.
- Include patient's insurance card(s) (both sides) and HMO authorization if required.
- For additional assistance, please call (505)-272-3160.

For: **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)

CONSULTATION REQUEST INFORMATION:

Diagnosis/ICD10: _____

Reason for Referral/Consultation: _____

REFERRING PHYSICIAN INFORMATION:

Referring Physician: _____ Specialty: _____

Phone: _____ Fax: _____

Practice Name: _____ Phone: _____

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.