



100 Far Horizons Lane Asheville, NC 28803 Phone 828.771.2219 Fax 828.771.2634 www.memorycare.org

New Patient Referral (To Be Completed By Referring Doctor's Office)
(Please send with this form the most recent progress notes, labs, neuroimaging, and any prior neuropsychological testing.)

Date of Referral: _____ Person Completing Form: _____

Patient Name: _____ DOB: _____

Patient Address: _____ SS#: _____ - _____ - _____

City: _____ State: _____ Zip: _____ County: _____

_____ Female _____ Male Phone: _____

REFERRING ENTITY MUST PROVIDE THIS INFORMATION FOR REFERRAL TO PROCEED

Family Member/Caregiver Name: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____ Relationship to patient: _____

Primary Insurance: _____ Policy/ID #: _____

Group #: _____ Name of Insured: _____

Secondary Insurance: _____ Policy/ID #: _____

Group #: _____ Name of Insured: _____

Responsible Party Name for Patient Billing: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Special Mailing Instructions: _____

Referred By: _____ NPI #: _____

Referring Physician: _____ Phone #: _____

Address: _____ Fax #: _____

City: _____ State: _____ Zip: _____



For MemoryCare Use Only:

Date of Appointment: _____ Time of Appointment: _____ am/pm Dr. _____

Physician Notified Date: _____ by: _____ Records Requested? Y/N

Packet sent: _____ by: _____ Records Received? Y/N

Comments: