The SECU Center for MemoryCare
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 Physician: _______________________________ **Phone:** ___________________ **Fax:** ____________________

Primary Insurance: ____ **ID#:** _________________________________

Secondary Insurance: ____ **ID#:** _________________________________

<u>REFERRING ENTITY MUST PROVIDE THIS INFORMATION FOR REFERRAL TO PROCEED</u>

Family Member/Caregiver Name: ____

Address: ____ **Phone:** ____________________

City: ____________________________ **State:** _____________ **Zip:** __________

Relationship to patient: ___________________________

For MemoryCare use only:

Date of Appointment: ____________________ Time of Appointment: ___________ am/pm Dr. ________________

Date of Disposition to Referring MD: ___________________

Packet 1 sent: ______________________________ Date PVQ/Deposit due: ___________________________

Packet 2 sent: ______________________________

Comments: