Duke Memory Clinic Referral Form

All sections must be filled out for the referral to receive review. Unfilled forms will be returned.
We review the referral and schedule according to the Duke Health System Memory Referral pathway.

Referring Provider Information

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Patient Information

Patient Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Contact Phone Number: _____

Referral **must include** the score for any ONE of the following Cognitive Tests

MOCA Score: _____

Date: Less than 6 mo ☐ 6 mo - 1 yr ☐ Greater than 1 yr ☐

MMSE Score: _____

Date: Less than 6 mo ☐ 6 mo - 1 yr ☐ Greater than 1 yr ☐

SLUMS Score: _____

Date: Less than 6 mo ☐ 6 mo - 1 yr ☐ Greater than 1 yr ☐

Referral **must include** an estimate of functioning (please check all that apply):

☐ No loss of ability ☐ Unable to manage finances, medications ☐ Unable to shop, drive ☐ Needs help to shower, dress

Is the patient's walking normal? Yes ☐ No ☐

Is the patient a significant fall risk? Yes ☐ No ☐

Can the patient be left alone for a day without issue ? Yes ☐ No ☐

Has the patient had a brain MRI in the last 2 years? Yes ☐ No ☐

Please fax the completed referral form to 919-668-0374.

DukeHealth