



Please Check (✓) the Appropriate Location for Patient Appointment

**Hollywood**  
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Pembroke Pines, Florida 33028  
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## Alzheimer's / Dementia Referral Form

Patient's Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Patient's Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_

Caregiver's Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Caregiver's Phone Number: \_\_\_\_\_ Patient's Phone Number: \_\_\_\_\_

Alternate Phone Number: \_\_\_\_\_ Patient's Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Reason for Scan / Clinical Question: \_\_\_\_\_

Symptoms of Cognitive Impairment: \_\_\_\_\_

Date of Onset of Symptoms: \_\_\_\_\_ MMSE (or similar) Test Score: \_\_\_\_\_

Date of (AAN Defined) comprehensive clinical evaluation: \_\_\_\_\_ *(copy of report must be included)*

Date(s) of MRI and/or CT: \_\_\_\_\_ *(copy of report(s) must be included)*

Has patient had a previous PET and/or SPECT study for this condition: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Medical Specialty: \_\_\_\_\_

Physician's Address: \_\_\_\_\_

Physician's Phone Number: \_\_\_\_\_ Physician's Fax Number: \_\_\_\_\_

Results:  Call Stat Report  Phone Report  Fax Report (Written Report to follow by mail.)

*PET is approved by the Centers for Medicare & Medicaid Services (CMS) for patients who meet diagnostic criteria for both Alzheimer's disease and fronto-temporal dementia, who have been evaluated for specific alternate neurodegenerative diseases or causative factors, and for whom the cause of the clinical symptoms remains uncertain.*

*To comply with CMS regulations our office must obtain each of the following documents prior to testing:*

- 1. Reports from any neurophysical testing performed*
- 2. Results of Structural Imaging (MRI or CT)*
- 3. Relevant laboratory test results (B12, thyroid hormone)*
- 4. List of prescribed medications*

Please sign/fax  
this document or  
send prescription

Referring Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_