THE Pat Summitt CLINIC
UT MEDICAL CENTER

1932 Alcoa Hwy
Medical Office Building C, Suite 150
Knoxville, TN 37920
865-305-2273 (Phone) | 865-305-7311 (Fax)

****REFERRAL WILL NOT BE PROCESSED IF ANY ITEM ON CHECKLIST IS MISSING****

Patient Referral Form

Patient Name: _____ DOB: _____

Address: _____

Referring Provider: _____ Referring Provider Phone: _____

Referring Provider Fax: _____ Ref. Provider Office Contact: _____

Primary Care Physician: _____ Primary Care Phone: _____

Patient's Contact Phone: _____ Alternate Phone: _____

Patient's Email Address:_____

Family/Caregiver Contact Name: _____

Family/Caregiver Contact Number: _____

Primary Insurance: _____ Referral/Authorization Required? Yes/No

Secondary Insurance: _____

Reason for Referral

Is this referral related to a recent hospitalization? Yes No (circle one)

Did the patient symptoms have a sudden, subacute, or insidious onset? (circle one)

Does the patient have any of the following?

- ☐ Abnormal movements
- ☐ Anxiety
- ☐ Changes in behavior or personality
- ☐ Chronic pain
- ☐ Concussion
- ☐ Depression
- ☐ Difficulties with Speech/Language
- ☐ Difficulties with ADLs
- ☐ Gait difficulties
- ☐ Frequent falls
- ☐ History of stroke or TIA
- ☐ Psychosis
- ☐ Trouble sleeping
- ☐ Memory loss
- ☐ Safety concerns
- ☐ Seizures
- ☐ Substance abuse
- ☐ Traumatic brain injury

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Is the patient being treated for dementia now or in the past, and if so, please list all dementia medications the patient has taken: _____

_____

Is the patient being treated for depression now or in the past, and if so, please list all antidepressant medications the patient has taken: _____

_____

Has the patient seen a neurologist or other memory specialist in the past? Y / N

If yes, name _____

Referral Checklist

- ☐ Patient and/or family member are aware of and agreeable to referral
- ☐ Patient and insurance demographics, including copy of front and back of insurance card(s)
- ☐ Two methods of contacting patient (include family/caregiver)
- ☐ Most recent note clearly addressing the reason for referral
- ☐ Brief standardized cognitive test within the last 6 months (e.g. MoCA or MMSE)
- ☐ MRI of the brain. **MUST INCLUDE**: Sagittal and coronal reconstructions, FLAIR and SWI or GRE sequences. If MRI is absolutely contraindicated, head CT **with** coronal and sagittal views is acceptable.
- ☐ Bloodwork within 6 months of referral. **MUST INCLUDE**: CBC, CMP, B12, MMA, TFT
- ☐ Complete and updated list of all medications, including OTC supplements

CLINIC USE ONLY:

Appointment Date: _____ Time: _____am/pm

Provider: _____ Location: UT Medical Center – Bldg. C, Suite 150

Images Requested via PACS or Disc? Date Requested/Initials: _____

****Referring provider- We must be able to confirm appointment with the patient/caregiver. The appointment will be cancelled should we not be able to confirm one week prior.****