Patient Referral Form

Thank you for choosing to refer your patient to us.
To begin the referral process, please **fax** this completed form to the UNM Appointment Center at **(505)-272-9427.**

- Include any pertinent medical records, including test results and imaging.
- Include patient's insurance card(s) (both sides) and HMO authorization if required.
- For additional assistance, please call (505)-272-3160.

For: **Center For Memory & Aging**

PATIENT INFORMATION:

Name: _____ DOB: _____
(first name) (last name) (dd/mm/yyyy)

Address: _____
(number) (street name) (unit)

_____
(city) (state) (postal code) (county)

_____
(phone) (alternate phone) (e-mail address)

CONSULTATION REQUEST INFORMATION:

Diagnosis/ICD10: _____

Reason for Referral/Consultation: _____

_____

_____

REFERRING PHYSICIAN INFORMATION:

Referring Physician: _____ Specialty: _____

Phone: _____ Fax: _____

Practice Name: _____ Phone: _____

_____
Signature