Keys2Memory®

...putting the heart first in neurocognitive disease care

Elena Schjavland, PhD CT-APRN
Adult-Geriatric Nurse Practitioner
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Consultation Request

PATIENT	Referral POC
Name: Address: DOB: Phone: ☐Call patient ☐Call Caregiver: Phone:	Name: Address: Phone: Email: Date of Referral: Patient's PCP:

SSN *(if different)* _____

☐Medicare _____ - _____ - _____ - __ (letter) ☐Medicaid/XIX_____

☐Other – supplemental *(attach insurance form info)*

Reason for Consult: ☐Memory Loss ☐Change in behavior ☐Self-neglect ☐Dementia ☐Other:

Medications:

☐Copy attached

Allergies: ☐NKDA ☐Other:

Areas of Concern:	**Additional Information:**
☐Cognitive Evaluation ☐Dementia Disease Staging ☐Dementia Behaviors: ☐Anxiety, ☐Depression, ☐Apathy, ☐Sundowning, ☐Psychosis ☐Functional Evaluation ☐Geriatric Assessment ☐Home safety ☐Driver Safety ☐Medication recommendations ☐Patient or Caregiver Education/Services ☐Referral for Research/Genetic Counseling ☐DNA testing for psychoactive meds *(Not always covered by insurance)*	

Please fax any helpful or applicable patient billing info, documentation, problem lists and lab-imaging results

Thank you for supporting early identification of cognitive disease.

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Welcome to Keys2Memory Health Services!

As a courtesy, we will bill your insurance for services provided. To ensure we have accurate information for your insurance company to process the bill, please complete the following:

Patient Name:	
Date of Birth:	
Social Security Number:	
Address:	
Contact phone# (and guarantor name if different from patient; POA/NOK):	
Medicare Number please include letter code	_____ - _____ - _____ ( ) letter
Medicaid - Title XIX#	
(☐HMO- PPO or Medicare Advantage, or ☐20% Medicare supplemental) Name and Address:	(Blue Cross, Empire, Tricare, Cigna, UnitedHealthcare, AARP, Sterling, etc.)
Member Identification Number#	
Group Number: Enrollment or Plan#	
Copay:	☐None ☐*I don't know* ☐YES, amount: $_____
☐ I do **not** have Medicare Co-Insurance	
Client/POA signature:	

If you have other insurance information, please continue on back or send copies of cards. If you are ineligible for Medicare/Medicaid or other private insurance, a bill will be sent to you or your family member Power of Attorney/Next of Kin. Signed consent agrees with payment, including **Medicare deductible and copays**.
Checks and credit cards are accepted. Payment plans are available.