Jacobs School of Medicine and Biomedical Sciences
Center of Excellence for Alzheimer's Disease
University at Buffalo

Alzheimer's Disease & Memory Disorders Center
PATIENT REFERRAL FORM
Please complete and fax to: 716-829-5051

Date: _____

Referring Provider: _____ Tel: ( ) _____

Patient Name:_____ DOB: _____ Sex: _____

Street Address: _____

City/State/Zipcode: _____

Patient Tel: ( ) _____ Okay to leave a message at this number ☐ Yes ☐ No

Caregiver Name: _____ Tel: ( ) _____

☐ Caregiver lives with patient Relationship to patient: _____

Other person to contact and their relationship to patient: _____

Brief description of diagnosis and/or presenting problem(s): _____

_____

_____

_____

_____

☐ Referral for consultation and diagnosis

☐ Referral to a clinical trial

I give permission for the referring provider to give my name, contact information and patient information to the Alzheimer's Disease and Memory Disorders Center / Center of Excellence for Alzheimer's Disease so that a staff member may contact me or my personal representative. I understand the health information may not be further used or disclosed unless another authorization is obtained by me or unless such disclosure is required or permitted by law.

Patient Signature: _____ Date: _____

POA Signature: _____ Date: _____

Office Locations: 1001 Main Street, Buffalo, NY 14203
5851 Main Street, Williamsville, NY 14221
(Tel) 716-829-5056 (FAX) 716-829-5051

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