Banner Alzheimer's Institute

Consultation Request

Date of Request: _____

Patient Name: _____ DOB _____

Primary Contact for Patient: _____ Relationship _____

Primary Contact Phone Number: _____

Diagnosis: _____

Preferred Provider: (leave blank if N/A) _____

Reason for Consultation: (Please check all that apply)

- ❑ Memory loss
- ❑ Other cognitive concern
- ❑ Possible dementia
- ❑ Unexplained neuropsychiatric or neurological syndrome
- ❑ Second opinion
- ❑ Other: _____

Desired Outcome: (Please check all that apply)

- ❑ Diagnostic work-up
- ❑ Medication recommendations
- ❑ Research recommendations
- ❑ Disease management recommendations
- ❑ Psychosocial intervention
- ❑ Other: _____

Referring Physician's Name: (Print) _____

Referring Physician's Signature: _____

If the patient's health insurance requires a pre authorization, please complete the following:

Insurance Name: _____ Subscriber: _____

Insurance Address: _____

Insurance Phone: _____ Contract ID #: _____

Authorization #: _____ Units/Visits: _____

901 E. Willetta Street • Phoenix, AZ 85006 • Phone: 602.839.6900 • Fax: 602.839.6906