CENTRO DE LA COMUNIDAD UNIDA
UNITED COMMUNITY CENTER

Froedtert & Medical College of Wisconsin

UCC Latino Geriatric Center/ Memory Clinic

730 W. Washington St, Milwaukee, WI 53204

Phone: (414) 649-2808 Fax: (414) 649-2824

Diagnostic Consultation & Services Referral

Please complete and fax or mail to address above:

Referral Information: **Referral Date** _____

Patient/Client Name:_____ DOB:_____

Address: _____ Phone:_____

_____ Female___ Male____

Ethnicity/Race _____ Primary Language Spoken: Spanish __ English __ Other __

1st Contact/Relationship: _____

Phone:_____

2nd Contact/Relationship: _____ Phone: _____

Referral Reason(s):

Why is patient/client being referred? Please check: (Fill the comments space as needed)

Senior Center (Social model/Nutrition Site for Self-independent 60 Years _____

Adult Day Care Services Recommendation_____ Memory Evaluation_____

Explanation/ Comments: _____

_____

_____

Referring provider/ PCP information:

Primary Care Physician: _____ Phone: _____

Clinic/hospital:_____ Fax:_____

Referring contact person (if different):_____ Phone:_____

Fax: _____ Email:_____ Organization:_____

Please include the following information with the referral form:

Current Diagnoses list, Current Medication list, Last MD visit note (if available), insurance information.

___ Attached ____Faxed ____Mailed ___Available upon request

Appointment Confirmation Contact:

Who do you wish to be contacted with appointment information? (Check all that apply).

___ Patient ___ Patient's Caregiver ___ Referring Agency

____Primary Care Physician: _____ Phone: _____

Referring Provider Signature:			**Date:**
Received at UCC:	**Staff:**	**Confirmed Receipt:**	**By: Phone/Fax/Email**

(rev.12/2013)