

**COMPREHENSIVE MEMORY CENTER**  
**Mulva Clinic for the Neurosciences at UT Health Austin**  
**Fax: 1-512-232-3899**

*Counseling Referral Form*

**PERSON BEING REFERRED**

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Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_

Primary Insurance: \_\_\_\_\_ Name of Policy Holder: \_\_\_\_\_

Member ID: \_\_\_\_\_ Group #: \_\_\_\_\_

**REFERRING HEALTH PROFESSIONAL**

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Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Clinic/Organization: \_\_\_\_\_ Fax: \_\_\_\_\_

**REASON FOR REFERRAL**

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\_\_\_\_\_ Person with cognitive impairment seeking individual counseling

\_\_\_\_\_ Family caregiver of a person with cognitive impairment seeking individual counseling

\_\_\_\_\_ Patient *and* family seeking family counseling

Specify type/stage of cognitive impairment: \_\_\_\_\_