**REQUEST FOR EVALUATION**

**\*Required Fiels**

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| **\*Patient contact information**  |
| Last Name :  | First Name :  |
| Date of birth :  | Phone N° :  |
| Address :  |
| Email : |
| Current living arrangements :⃝ Home ⃝ EMS/other institution ⃝ Other :  |
| Insurance coverage : ⃝ Swiss ⃝ Foreign or no insurance coverage |

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| **\*Urgent Request** |
| ⃝ **No** | ⃝ **Yes**, clarification :  |

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| **\*CONTACT DETAILS OF THE PERSON REQUESTING THE EVALUATION**  |
| ⃝ **Doctor** | ⃝ Family Physician ⃝ Other doctor  |
| Last name, First name :  |
| Phone N° : |
| Email :  |
| ⃝ **Family Member** | Last name, First name :  |
| Family Link *(husband, son, etc.)* :  |
| Phone N° : |
| Email :  |
| ⃝ **Patient himself** |

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| **\*CONTACT PERSON FOR APPOINTMENTS** |
| ⃝ **Patient himself** |
| ⃝ **Family Member** | Last name, First name :  |
| Family Link *(husband, son, etc.)*:  |
| Phone N° : |
| Email :  |

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| **\*AVAILABLE COGNITIVE TESTS**  |
| **⃝ Never** | **⃝ Yes**, at the Centre de la Mémoire, specify date : **⃝ Yes**, elsewhere, specify date and place:  |

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| **\*AVAILABLE EXAMS : Please attach to this request** |
| ⃝ **Blood tests** *(including B12, folates, calcium and TSH)* ⃝ **Neuroimaging** *(if there is no neuroimaging, please do not prescribe, as we prefer to have it with using a standardized procedure)* ⃝ **Cognitive tests/previous neuropsychological tests** *(including reports and test results)* |
| **CRITERIA DEFINING A PERSON AT HIGH RISK FROM THE NEW CORONAVIRUS** |
| **In order to respond more quickly to your request and facilitate the patient’ medical care at the Center, please check the boxes for the presence of risk factors.****The patient ⃝ tested positive for Covid-19**  **⃝ is over 65 years of age** **⃝ affected by certain diseases:**  ⃝ high blood pressure ⃝ diabetes  ⃝ cardiovascular disease ⃝ chronic respiratory disease ⃝ immune weakness due to disease or treatment or cancer |
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| **PATIENT’S PROF** |
| ⃝ No memory/cognitive disorders, but the patient wants to perform a check-up ⃝ Memory/Cognitive disorders,worrying : ⃝ Patient  ⃝ Family ⃝ Family Physician ⃝ Cerebrovascular disease *(TCC, AVC, … )*⃝ Suspicion of mental retardation or low intellectual efficiency⃝ Anxiety or depressive disorder⃝ Obvious or known psychiatric disorders, specify *(schizophrenia, psychosis, mood disorder or bipolar, adaptation, of the personality, substance abuse or addiction, … )* :⃝ Other known diseases or other profile, specify :  |
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| **REASON FOR REQUEST** |
| **⃝ First cognitive evaluation** **⃝ Second advice****⃝ Cognitive follow-up evaluation****⃝ Psychological aid for ⃝ Patient ⃝ Family** **Diagnosis and treatment :**⃝ Driving aptitude *(attach any relevant documents or correspondence).*⃝ Intellectual efficiency ⃝ without ⃝ with IQ estimation⃝ Competence assessment, specify a concrete situation *(please note that we do not carry out legal expertise and that we are bound by professional secrecy)*:⃝ Participation in a clinical trial *(with experimental medicines)*⃝ Other cause, specify :  |

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| **OTHER USEFUL INFORMATIONS** |
| **French fluency :** ⃝ Sufficient for a clinical dialogue ⃝ Insufficient, translator required. Specify the language :**Educational level :**  ⃝ Primary school only ⃝ Less than 5 years of schooling ⃝ Illiteracy |
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**PROCEDURE AFTER RECEIPT OF THE REQUEST**

* The contact person for appointments will be contacted by the secretariat to arrange the appointment. After three consecutive failed contacts, a letter will be sent to the person requesting the evaluation and the file closed. If appropriate, the latter will need to contact us again to re-open the file.
* No shows will be invoiced.
* After two no shows, a communication will be sent to the person requesting the evaluation and the file will be closed.

***Please forward your evaluation request:***

***By fax***to 022 372 58 15 or ***by post at*** Hôpitaux Universitaires de Genève, Centre de la Mémoire, 6 rue Gabrielle-Perret-Gentil, 1211 Genève 14