WHAT IS GMN?

Georgia Memory Net helps PCPs get timely & accurate diagnoses for their patients who exhibit signs of memory loss or cognitive impairment. Then we provide planning and connection to community services to support Primary Care Providers in the ongoing care of their patients. Georgia Memory Net is made possible by a mandate from Georgia State Legislature.

YOUR ASSESSMENT AND REFERRAL BEGINS THE PROCESS

START

PCP refers patient to one of Georgia Memory Net’s Memory Assessment Clinics for in-person or telemedicine visits.

REFERRAL

Diagnosis and personalized care plan shared with PCP, who manages patient’s ongoing care.

WARM HANDOFF

Patient and Care Partner have a clear path for the best care possible.

DIAGNOSED

PATIENTS RETURN TO PCP FOR ONGOING CARE

ASSESSMENT

PCP assesses patient’s memory and cognitive ability, through the Annual Wellness Visit or other observations.

DIAGNOSIS & EDUCATION

Patient receives timely diagnosis and is connected with community support services.

REFERRALS

CRITERIA FOR REFERRAL

Criteria for a referral to a Georgia Memory Net Memory Assessment Clinic:

- Cognitive screening with impaired scores (all tools welcome; i.e. Mini-Cog, MMSE, MOCA, bedside cognitive exam)
- Observed or reported symptoms typical of memory loss, mild cognitive impairment, or dementia

It’s preferable, but not required, to rule out other possible causes of these symptoms.

HOW TO REFER

Internal

Place order in local system (CPOE)

External

Complete and send the attached referral request form to the Memory Assessment Clinic convenient to your patient. Please include any applicable labs, scans, or other pertinent information.

info@GaMemoryNet.org // GaMemoryNet.org

Sponsored by the Georgia Department of Human Services.
Managed by the Goizueta Alzheimer’s Disease Research Center at Emory University.
Referral Request:
Thanks for partnering with Georgia Memory Net. We’re dedicated to providing your patients with an accurate diagnosis, and then returning them to your capable care.

Date of Referral: __________________________________________

☐ Georgia Resident

Patient:
Last Name: ________________________________________________
First Name: ________________________________________________
MI: ______________________ DOB: _____________________________
Gender: M / F (circle one)
Marital Status: ____________________________________________
Home Phone: ______________________________________________
Mobile Phone: ______________________________________________
Email: _____________________________________________________
Address: __________________________________________________
City: _______________________________________________________
State: ______________________________________________________
Zip: ________________________________________________________
Country: ___________________________________________________
Primary Language: __________________________________________
Interpreter required? N / Y (circle one)
Type: ______________________________________________________

Family Caregiver/Emergency Contact:
Name: _____________________________________________________
Preferred Phone: ___________________________________________
Email: _____________________________________________________

Patient Insurance:
Insurance Carrier: __________________________________________
Member ID: _________________________________________________
Group Number: _____________________________________________
☐ Copy of Insurance Card Attached

Referring Provider:
Referring Provider Name: ____________________________________
Provider NPI Number: _______________________________________
Address: __________________________________________________
City: _______________________________________________________
State: ______________________________________________________
Zip: ________________________________________________________
Phone: _____________________________________________________
Fax: _______________________________________________________
Email: _____________________________________________________

Please include the following:
• Annual Wellness Visit notes including which Cognitive Screening Tool used and outcomes

If available, please also include the following:
• Recent labs (within past year) including comprehensive metabolic, CBC, B12 level, TSH, Lipid panel, HgbA1c, RPR
• List of current medications
• Brain imaging report
• Actual brain images
• Problem list
• Allergies
• Relevant clinical notes
• Brain MRI (or CT if patient has pacemaker, mechanical heart valve/stents or previous injury involving metallic object) within the past year

Fax these documents and a completed referral form to the Memory Assessment Clinic convenient to your patient:

Albany
Fax: 229-312-8595, Phone: 229-312-8590
Attn: Shaneka Wiggins, Medical Assistant
GMN Memory Assessment Clinic at Phoebe Primary Care at Northwest

Atlanta
Fax: 404-616-4260, Phone: 404-616-4567
Attn: GMN Memory Assessment Clinic at Grady Memorial Hospital

Augusta
Fax: 706-446-0212, Phone: 706-721-2798
Attn: Kristine Cordero, Project Coordinator
GMN Memory Assessment Clinic at MCG Augusta University

Columbus
Fax: 706-571-1603, Phone: 706-571-1120
Attn: Scheduling Coordinator
GMN Memory Assessment Clinic at Piedmont Columbus Regional Family Medicine Center

Macon
Fax: 478-784-5496, Phone: 478-633-5686
Attn: Veronda Perkins, Practice Manager
GMN Memory Assessment Clinic at Navicent Health — Family Health Center

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