Brain Fitness Centers
OF FLORIDA, LLC.

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Cognitive Rehabilitation ASSESSMENT and TREATMENT referral form

Symptoms

☐ Difficulty with simple tasks	☐ Distracted	☐ Balance challenges / Fall risk
☐ Struggle to follow instructions	☐ Difficulty Prioritizing	☐ Slow decision making ability
☐ Not sleeping well	☐ Impaired communication	☐ Depression / Removed from socializing
☐ Memory Issues	☐ Mild Aphasia	☐ Often losing things (e.g., keys, glasses) needed to complete tasks
☐ Disused Brain	☐ Care Taker Brain	

Home health precludes a patient from participating until released

Date: _____

Referring Healthcare Provider: _____

Physician's name/Speciality: _____

Address: _____

Phone: _____

Physician Signature: _____

Patient Name: _____

DOB: _____

Phone: _____

***Please include:**

1. *Current Progress Notes*
2. *Demographics & Insurance Information*
3. *MRI if available*

◯ included

◯ None on file within last 3 years

Recommend your patients be assessed if you have concerns for their:

Safety | Physical and emotional health | Well being