

**Saint Luke's Brain and Stroke Institute
Brain Fitness Center
4400 Broadway Kansas City, MO 64111
Medical Referral Form**

Patient Name: _____ **DOB:** ___/___/___
Home address: _____

Patient telephone: _____

Diagnosis:

- Alzheimer's Disease
- Mild Cognitive Impairment
- Early Memory Impairment
- Stroke
- TBI
- Other: _____

Treatment:

- Brain Fitness Gym
- Cognitive Evaluation
- Cognitive Treatment
- Alzheimer's Functional Maintenance Plan Establishment/ Reevaluation
- Other: _____

Physician Signature: _____

Print Last Name : _____

Physician telephone: (____) ____ - _____

FAX to Brain Fitness Center: 816/932-4573

or e-mail: BrainFitness@saint-lukes.org