

EMORY HEALTHCARE
THE EMORY CLINIC, INC.
WESLEY WOODS HEALTH CENTER
1841 Clifton Road, NE, 4th Floor
Atlanta, GA 30329
404-728-6302

Thank you for allowing us to assist in your care. We look forward to meeting you.

Symptoms of depression, anxiety and memory problems can either be the result of a medical illness or biological changes in the brain and are often difficult to separate from normal changes which take place as a result of getting older. The great news is that the majority of people who suffer from these symptoms can be helped and the Emory Division of Geriatric Psychiatry clinical team is here to help.

Your appointment is with members of our Emory Division of Geriatric Psychiatry clinical team who will provide a thorough evaluation and make recommendations regarding treatment for you. We will communicate our recommendations with your primary care provider or other referring physician so that your medical and psychiatric care is well coordinated. Our psychiatry clinical team may need to see you several times prior to referring you back to your primary care or referring physician. Frequently, adequate treatment requires us to work with other providers both here at Emory and in the community; we will make certain you are referred to the appropriate specialists and that your treatment is coordinated.

So that we can best care for you, please have medical records from your referring physician or a letter describing the reason for the referral mailed or faxed to 404/728-6269 PRIOR to your appointment. If you need assistance in obtaining your medical records, we will be happy to request them from your physician(s) for you. However, in order for us to do so, you will need to complete one copy of the **Authorization for the Release of Protected Health Information form** (enclosed) for each physician we need to contact. Either fax (404-728-6269) or mail the consent form to us as soon as possible to allow time for the request to be processed prior to your appointment.

It is imperative that you BRING THE FOLLOWING WITH YOU TO YOUR APPOINTMENT:

- 1. Completed New Patient Information Packet (enclosed)**
- 2. All of your medications in their prescription bottles – We will need your PHARMACY ADDRESS (not phone #)**
- 3. Completed Authorization for the Release of Protected Health Information Form (enclosed)**
- 4. All insurance cards (including Medicare and your secondary plan if you have one)**

Thoroughly completing the New Patient Information Packet will allow your clinician to spend more time during the visit addressing your individual questions and concerns.

Our office and registration is located on the 4th floor of the Wesley Woods Health Center, 1841 Clifton Road NE, Atlanta, GA 30329. **Directions to our office are included in this packet of information. Please arrive 30 minutes prior to your appointment to register.** In order to honor all of our patients scheduled appointments, any patient arriving more than 20 minutes late will be rescheduled.

In order to decrease the time it takes to register you for your appointment, you can fax a copy of your insurance card(s) to 404-728-6269 prior to the day of your appointment.

Again, we look forward to meeting you. Please feel free to call us at **404-728-6380** if you have any questions.

Sincerely,

William McDonald, MD
Chief, Division of Geriatric Psychiatry
Director, Fuqua Center for Late-Life Depression

New Patient Packet 032211

The Emory Neuropsychiatry Clinic at Wesley Woods is a specialized clinic that provides consultations, second opinions, and long-term patient follow-up care. Physicians are Emory Clinic faculty and fellows who have specialized training in geriatric psychiatry/neuropsychiatry. Our nurse practitioners/clinical nurse specialists (NP/CNS) have also received additional training in geriatric psychiatry/neuropsychiatry. A team of physicians and advanced practice nurses (NP/CNS) will be taking care of you. Our program is one of the largest of its kind in the United States offering a full range of neuropsychiatric evaluations, including opportunities to participate in research studies. You can find out more about our clinic and physicians on the web at <http://fuquacenter.org>.

Our clinic consists of the following providers:

William McDonald, M.D. JB Fuqua Chair and Professor of Psychiatry and Behavioral Sciences
Chief of Geriatric Psychiatry
Certified by the American Board of Psychiatry and Neurology
Added Qualifications in Geriatric Psychiatry

Raymond Young, M.D. Assistant Professor of Psychiatry and Behavioral Sciences
Director of Outpatient Clinical Services
Certified by the American Board of Psychiatry and Neurology
Added qualifications in Psychosomatic Medicine
Certified by the American Board of Internal Medicine

Adriana Hermida, M.D. Assistant Professor of Psychiatry and Behavioral Sciences
Certified by the American Board of Psychiatry and Neurology
Board certified in Geriatric Psychiatry

Hisam Goueli, M.D. Assistant Professor of Psychiatry and Behavioral Sciences
Director of Inpatient Psychiatry at Wesley Woods
Board Eligible by the American Board of Psychiatry and Neurology
Board Certified in Family Medicine

Larry Tune, M.D. Professor of Psychiatry and Behavioral Sciences
Director of Inpatient Neuropsychiatry at Wesley Woods
Certified by the American Board of Psychiatry and Neurology
Added Qualifications in Geriatric Psychiatry

Eve Byrd, MSN, MPH, APRN-BC
Executive Director, Fuqua Center for Late-Life Depression
Adjunct Faculty, Emory School of Nursing
Certified by American Nurses Credentialing Center

Sherry Dey, MN, APRN-BC
Certified by American Nurses Credentialing Center

Marye McKenney, MSN, RN, GNP, ANP
Certified by American Nurses Credentialing Center

EMORY HEALTHCARE

New Patient Information Packet

Name: _____ Date: _____

Date of Birth: _____ Age: _____

Address: _____

Name of retirement home, assisted living facility or nursing home, if applicable:

Family Members/Contact Persons:

Name: _____ Name: _____

Relationship to Patient: _____ Relationship to Patient: _____

Address: _____ Address: _____

Telephone (Home): _____ Telephone (Home): _____

Telephone (Other): _____ Telephone (Other): _____

<p>PHARMACY NAME _____</p> <p>PHARMACY ADDRESS (address required) _____</p>

Referring Physician:

Internal Medicine/Family Physician:

Name: _____ Name: _____

Address: _____ Address: _____

Telephone: _____ Telephone: _____

Fax: _____ Fax: _____

<p>I understand that in providing this information, I am giving the staff at the Geriatric Psychiatry Clinic permission to communicate with these family members and physicians, if the need arises.</p> <p>X _____ Patient's Signature (or legally authorized representative)</p>
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History of Present Illness

Please describe the main problem or the reason for making this appointment _____

When did symptoms begin? _____

Have you been treated for this problem before? Yes No

If yes, please describe the treatment including dates: _____

Review of Common Symptoms

For the following symptoms, please indicate whether you are currently experiencing this, experienced this in the past, or never experienced this. **Give dates, duration of symptoms and details when applicable.**

When did this occur?			Symptom
Current	Past	Never	
			Depression, persistent sadness or feeling blue
			Loss of pleasure in activities
			Decreased motivation
			Crying spells
			Lack of energy or fatigue
			Loss of appetite
			Difficulty falling asleep
			Waking up multiple times during the night
			Awake early and can not return to sleep
			Increased sleep
			Nightmares
			Difficulty concentrating
			Memory problems
			Anxious or restless
			Irritable mood
			Feelings of guilt or worthlessness
			Low self-esteem
			Feelings of hopelessness
			Self-injurious behavior (such as cutting or burning yourself)
			Feeling like you wish you were dead
			Thoughts of suicide
			Thoughts of hurting someone else
			Aggressive/combatative behavior
			Racing thoughts
			Talking more than usual
			Increased activity (such as writing, cleaning, or exercising more)
			Increased risk-taking behavior
			Not eating or weight loss without trying to lose weight

		Not eating in order to lose weight
		Exercising to lose weight
		Using laxatives to lose weight
		Using other methods to lose weight
		Overeating without feeling hungry
		Binging (eating large amounts)
		Obsessive thoughts (symmetry, cleanliness, intrusive thoughts)
		Intrusive thoughts about something bad that happened to you
		Compulsive behaviors (counting, washing hands, cleaning)
		Trouble with self-care (such as dressing or bathing)
		Seeing or hearing something that others can't
		Flashbacks about something bad that happened to you
		Panic attacks
		Anxiety about social situations (such as speaking in public)
		Paranoia (suspiciousness)
		Reading other people's thoughts
		Feeling that your thoughts are being read
		Feeling like the television or radio is talking to you specifically

Have you ever been hospitalized for a mental/psychiatric illness? If so, please list dates and the hospital:

Medical History

Please list any serious illnesses or ongoing medical problems you have ever had. Include any surgical procedures.

Dates

Problem

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Review of Symptoms

Please check any of the following that pertain to you. **Give dates, duration of symptoms and details when applicable.**

Heart Disease

Chest Pain

At rest _____

With activity _____

Swollen ankles _____

Difficulty breathing when walking or with activity _____

Palpitations or heart racing _____

High blood pressure _____

High cholesterol _____

Dizziness or fainting _____

Neurological

Head injury _____

Seizures or fits _____

Headaches _____

Falling _____

Problem with balance _____

Feels dizzy when stands up _____

Tremor or difficulty writing _____

Sleep problems such as loud snoring, gasping for breath, daytime sleepiness or limb jerking _____

Numbness or tingling _____

Forgetfulness _____

Confusion _____

Difficulty speaking _____

Difficulty finding your way _____

Difficulty managing finances _____

Difficulty maintaining home _____

Sensations

Problems with sense of smell _____

Problems with taste _____

Problems with hearing _____

Uses hearing aid _____

Eye pain _____

Blurred or double vision _____

Sensitive to glare _____

Respiratory

Cough _____

Asthma or wheezing _____

Gastrointestinal

- Problems swallowing _____
- Burning in chest or stomach after meals or when lying down _____
- Constipation _____
- Diarrhea _____
- Change in color of stool/black or tarry stools _____

Genital/urinary

- Loss of interest in sex _____
- Difficulty maintaining an erection _____
- Delayed ejaculation _____
- Pain with intercourse _____
- Difficulty urinating _____
- Difficulty holding urine _____
- Trouble starting stream, dribbling or reduced stream _____
- Pain when urinating _____
- Need to urinate more frequently _____
- Frequent urinary tract infections _____

Musculoskeletal

- Difficulty standing up from sitting _____
- Stiffness or pain in joints _____
- Pain worse in the morning and decreases with activity _____
- Back or neck pain _____
- Other pain _____

Hematological

- Anemia or low blood _____
- Excessive bruising or bleeding _____
- Recurrent infections or infections that will not go away _____

Endocrine

- Thyroid disease _____
- Weight gain or loss _____
- Skin changes _____
- Hair changes _____
- Voice changes _____
- Cold or heat intolerance _____

Allergies (List any medication, food or other allergies) _____

Please review the following list of psychiatric medications and treatments to provide information on those you have ever used/received.

	Treatment	Maximum Daily Dose	Approximate Dates	Duration (weeks)	Response
Tricyclic	Amitriptyline (<i>Elavil</i>)				
	Imipramine (<i>Tofranil</i>)				
	Desipramine (<i>Norpramin, Pretrofane</i>)				
	Clomipramine (<i>Anafranil</i>)				
	Maprotilene (<i>Ludiomil</i>)				
	Doxepin (<i>Sinequan</i>)				
	Nortriptyline (<i>Pamelor</i>)				
SSRI	Fluoxetine (<i>Prozac</i>)				
	Fluvoxamine (<i>Luvox</i>)				
	Paroxetine (<i>Paxil</i>)				
	Paroxetine CR (<i>Paxil CR</i>)				
	Sertraline (<i>Zoloft, Lustral</i>)				
	Citalopram (<i>Celexa, Cipramil</i>)				
	Escitalopram (<i>Lexapro</i>)				
SNRI & Other	Bupropion (<i>Wellbutrin, Zyban, Budeprion</i>)				
	Mirtazapine (<i>Remeron</i>)				
	Duloxetine (<i>Cymbalta</i>)				
	Venlafaxine (<i>Effexor</i>)				
	Nefazodone (<i>Serzone</i>)				
	Trazodone (<i>Desyrel</i>)				
	Amoxapine (<i>Asendin</i>)				
	Desvenlafaxine (<i>Pristiq</i>)				
	Aplezin				
MAOI	Phenelzine (<i>Nardil</i>)				
	Tranlycypromine (<i>Parnate</i>)				
	Isocarboxazid (<i>Marplan</i>)				
	Selegeline oral (<i>Deprenyl</i>)				
	Selegeline transdermal (<i>Emsam</i>)				
Mood stabilizers	Lithium (<i>Eskalith, Lithobid, Duralith, Lithonat</i>)				
	Lamotrigine (<i>Lamictal</i>)				
	Valproic acid (<i>Depakene</i>)				
	Divalproex (<i>Depakote</i>)				
	Valproate (<i>Depakote, Depacon</i>)				
	Carbamazepine (<i>Tegretol, Equetro</i>)				
	Topiramate (<i>Topamax</i>)				
	Oxcarbazepine (<i>Trileptal</i>)				
	Gabapentin (<i>Neurontin</i>)				

	Treatment	Maximum Daily Dose	Approximate Dates	Duration (weeks)	Response
Psychotropics	Quetiapine (Seroquel)				
	Ziprasidone (Geodon)				
	Olanzapine (Zyprexa)				
	Aripiprazole (Abilify)				
	Haldol				
	Clorazil				
	Thorazine				
	Mellaril				
	Prolixin				
	Stelazine				
	Navane				
	Risperdal (Risperidone)				
	Symbyax				
Benzodiazepines	Xanax (alprazolam)				
	Buspar (buspirone)				
	Klonopin (clonazepam)				
	Valium (diazepam)				
	Ativan (lorazepam)				
	Prosom				
	Restoril (temazepam)				
	Halcion				
Sleep Agents	Rozerem				
	Ambien (zolpidem)				
	Sonata				
	Lunesta				
Stimulant	Methylphenidate (Ritalin, Concerta, Metadate, Focalin)				
	Adderall				
	Strattera (atomoxetine)				
	Modafinil (Provigil)				
Cognitive enhancers	Aricept				
	Namenda				
	Exelon				
	Galantamine				
Psychotherapy	Cognitive behavioral				
	Interpersonal				
ECT	Unilateral or unknown	# of treatments:			
	Bilateral	# of treatments:			

Please mark any medication you have ever taken and add as much detail as possible. Completing this information ahead of time will allow us to help you better and choose the right medication for you.

Other medications currently taking:

Medication	Dosing Schedule
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Family Medical/Psychiatric History

List all of your immediate family (parents, siblings, and children). Under illnesses, list serious illnesses or diseases, especially **psychiatric/mental illnesses**.

Relationship	Age	Illness/Cause of death
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Social History

Birthplace and where you were raised _____
 How far did you go in school? _____ Degrees earned _____
 Married for how long? _____ Divorced _____ Widowed _____ Single _____
 Occupation(s) prior to retiring _____
 Smoking: Number of years _____ Packs per day _____
 History of alcohol abuse or addiction? _____
 Alcohol: approximate drinks per week _____
 Exercise: Type _____ Frequency: _____
 Hobbies, interests _____
 With whom do you live? _____

Please list all social/medical support services and the agency you receive them from (such as a case manager, social worker, homemaker or home health aid services, senior center, home healthcare, home delivered meals, adult protective services, etc):

Service	Agency Providing Service
_____	_____
_____	_____
_____	_____
_____	_____

Is there any other information you want to share with us? _____

Please complete the following scale to help us assess depressive symptoms.

	Yes	No	
1			Are you basically satisfied with your life?
2			Have you dropped many of your activities and interests?
3			Do you feel that your life is empty?
4			Do you often get bored?
5			Are you hopeful about the future?
6			Are you bothered by thoughts that you can't get out of your head?
7			Are you in good spirits most of the time?
8			Are you afraid that something bad is going to happen to you?
9			Do you feel happy most of the time?
10			Do you feel helpless?
11			Do you often get restless and fidgety?
12			Do you prefer to stay at home, rather than going out and doing new things?
13			Do you frequently worry about the future?
14			Do you feel you have more problems with your memory than most?
15			Do you think it is wonderful to be alive now?
16			Do you often feel downhearted and blue?
17			Do you feel pretty worthless the way you are now?
18			Do you often worry a lot about the past?
19			Do you find life very exciting?
20			Is it hard for you to get started on new projects?
21			Do you feel full of energy?
22			Do you feel that your situation is hopeless?
23			Do you think that most people are better off than you are?
24			Do you frequently get upset over little things?
25			Do you frequently feel like crying?
26			Do you have trouble concentrating?
27			Do you enjoy getting up in the morning?
28			Do you prefer to avoid social gatherings?
29			Is it easy for you to make decisions?
30			Is your mind as clear as it used to be?



Medical Record Number: _____
(for internal purposes)

**AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION
MEDICAL RECORDS DEPARTMENT**

Patient Name: _____ Social Security Number: _____

Previous Name, if applicable: _____ Date of Birth: _____

Address: _____ City: _____ State: _____

Zip Code: _____ Home Phone: _____ Work Phone: _____

1. EMORY HEALTHCARE FACILITY/FACILITIES:

I authorize representatives from the following facility/facilities to disclose the health information as directed below:

Check only one: (separate request form required for records from each facility desired)

- | | |
|--|---|
| <input type="checkbox"/> The Emory Clinic | <input type="checkbox"/> Emory University Hospital Midtown (formerly Crawford Long) |
| <input type="checkbox"/> Emory University Hospital | <input type="checkbox"/> Wesley Woods Geriatric Hospital |
| <input type="checkbox"/> Center for Rehab. Medicine | <input type="checkbox"/> Wesley Woods Outpatient Clinic |
| <input type="checkbox"/> Emory Children's Center | <input type="checkbox"/> Wesley Woods Long Term Care Hospital |
| <input type="checkbox"/> Emory Medical Affiliates | <input type="checkbox"/> Budd Terrace |
| <input type="checkbox"/> Dialysis Access Center of Atlanta | <input type="checkbox"/> Emory University Orthopedic and Spine Hospital |

2. RECEIVING PARTY

Please send my health information to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

*Fax Number: * for medical purposes only (emergent or in office) _____

3. DESCRIPTION OF HEALTH INFORMATION TO BE DISCLOSED:

- Complete medical record (*Please specify dates of service*) _____
- OR -**
- Partial medical record (*Please check specific sections needed below*)
- You must check this box if you are also requesting Billing Records*

Information	Dates	Information	Dates
<input type="checkbox"/> History & physical	_____	<input type="checkbox"/> Office notes	_____
<input type="checkbox"/> Consultations	_____	<input type="checkbox"/> Operative reports	_____
<input type="checkbox"/> Discharge summary	_____	<input type="checkbox"/> Pathology reports	_____
<input type="checkbox"/> Lab results	_____	<input type="checkbox"/> EKG reports	_____
<input type="checkbox"/> X-ray Reports	_____		
<input type="checkbox"/> CD / Films	_____		

Other (*Please specify content and dates of service*): _____



Medical Record Number: _____
(for internal purposes)

4. PURPOSE OF DISCLOSURE

- At my request
- Other: _____

5. EXPIRATION OF AUTHORIZATION

Unless I request in writing otherwise, I understand that this authorization will expire on _____
_____ (Insert expiration date or event). If I do not specify an expiration date or event, this authorization will expire ninety (90) days from the date on which I signed this authorization.

6. RIGHT TO REVOKE AUTHORIZATION

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Records Department(s) of the Emory Healthcare facility or facilities checked above. A list of addresses for the Medical Records Departments is contained in the Emory Healthcare, Inc. Notice of Privacy Practices. I understand that the revocation will not apply to any health information that has already been released in response to this authorization.

7. RE-DISCLOSURE

I understand that if my health information is disclosed to a party other than a health care provider, health plan or health care clearinghouse subject to the federal privacy regulations, my health information disclosed pursuant to this authorization may no longer be protected by the federal privacy regulations.

8. FEES

I understand that federal and state laws allow a fee to be charged for the copying of patient records and I will be responsible for the payment of such fees.

9. REFUSAL TO AUTHORIZE USE AND/OR DISCLOSURE

If I have been asked to sign this form in order to authorize the disclosure of my health information for purposes related to research, or for other reasons, I understand that Emory Healthcare may decline to treat me if I refuse to sign this authorization only if: (1) the treatment would be related to a research project and this authorization is for the use or disclosure of my health information for such research; or (2) the treatment would be for the sole purpose of creating health information for disclosure to a third party (such as a workers compensation examination).

10. RELEASE AND WAIVER

If the health information that I have requested Emory Healthcare to disclose contains any privileged psychiatric or psychological information related to the treatment of physical and/or mental illness, chemical dependency or alcohol abuse, or testing or treatment of any communicable or infectious disease such as acquired immunodeficiency syndrome (AIDS), Immunodeficiency Syndrome Related Complex (ARC), human immunodeficiency virus (HIV), Venereal Disease, Tuberculosis, or Hepatitis, I hereby waive any privilege concerning such information for the purpose(s) of releasing it to the party or parties authorized above. I also release Emory Healthcare, each of the Emory Healthcare facilities checked above, and their officers, trustees, agents and employees from any and all liabilities, damages and claims, which might arise from the release of the health information authorized by me above.

Signature of Patient (or Patient's Representative)

Date

Description of Authority to Act for Patient

NOTE: A COPY OF THIS COMPLETED, SIGNED AND DATED FORM MUST BE PROVIDED TO THE PATIENT AND/OR PATIENT'S REPRESENTATIVE AND A COPY MUST BE PLACED IN THE PATIENT'S MEDICAL RECORD

DIRECTIONS to GERIATRIC PSYCHIATRY

**Wesley Woods Health Center, 4TH Floor
1841 Clifton Road NE, Atlanta, GA 30329
404-728-6302**

From Perimeter East (east of Atlanta/I-285): From the eastern side perimeter (I-285), exit I-285 to Stone Mountain Freeway/Hwy 78 toward Decatur, Exit #39A. Stay in the left lane, and it will merge onto Lawrenceville Highway. Lawrenceville Highway turns into Scott Blvd. Turn RIGHT from Scott Blvd onto North Decatur Road (this is a six-way intersection). N. Decatur Road will not be the immediate right, but the “second” right. Stay on N. Decatur Road through the intersection with Clairmont Road. Turn RIGHT onto Clifton Road from N. Decatur Road. Continue on Clifton Road past Emory Hospital and the CDC. At the bottom of a hill, after several lights (and as you are going down a big hill) you will see the sign for Wesley Woods on your right (if you hit Briarcliff Road, you have gone too far). Turn RIGHT into the Wesley Woods Center campus. Follow directions in the box at bottom of the page for after you enter the campus.

From North (I-285 to I-85): Take I-285 to I-85 South towards Atlanta and exit North Druid Hills Road #89. Turn LEFT ONTO North Druid Hills Road. At the first major intersection, turn RIGHT onto Briarcliff Road (there is a QT & Chik-fil-A at this intersection). Travel 1 mile and make a LEFT onto Clifton Road (if you pass an Eckerd/Kroger Shopping Center on your left, you have gone too far). At the 1st traffic light, make a LEFT into the Wesley Woods Center campus. Turn RIGHT into the Wesley Woods Center campus. Follow directions in the box at bottom of the page for after you enter the campus.

From the South (including airport): Continue on I-85 North. Exit at North Druid Hills Road, exit #89. From the airport and I-85 Northbound, turn RIGHT off the ramp. At the first major intersection, turn RIGHT onto Briarcliff Road (there is a QT & Chik-fil-A at this intersection). Travel 1 mile and turn LEFT onto Clifton Road (if you pass an Eckerd/Kroger Shopping Center on your left, you have gone too far). At the 1st traffic light, turn LEFT into the Wesley Woods Center campus. Turn RIGHT into the Wesley Woods Center campus. Follow directions in the box at bottom of the page for after you enter the campus.

From I-20: Take I-20 toward Atlanta and exit at the I-85/I-75 connector NORTHBOUND. Stay on I-85/I-75 until it splits in the city and then follow I-85 NORTH. Exit at #89 North Druid Hills Road and make a RIGHT off the ramp. Go to the 2nd traffic light and make a RIGHT onto Briarcliff Road (there is a QT & Chik-fil-A at this intersection). Travel 1 mile and make a LEFT onto Clifton Road (if you pass an Eckerd/Kroger Shopping Center on your left, you have gone too far). At the 1st traffic light, make a LEFT into the Wesley Woods Center campus. Turn RIGHT into the Wesley Woods Center campus. Follow directions in the box at bottom of the page for after you enter the campus.

From I-75: Continue on I-75 toward Atlanta. Exit for I-85 North and continue to Exit #89 North Druid Hills Road. Turn RIGHT off the ramp. At the first major intersection, turn RIGHT onto Briarcliff Road (there is a QT & Chik-fil-A at this intersection). Travel 1 mile and make a LEFT onto Clifton Road (if you pass an Eckerd/Kroger Shopping Center on your left, you have gone too far). At the 1st traffic light, make a LEFT into the Wesley Woods Center campus. Turn RIGHT into the Wesley Woods Center campus. Follow directions in the box at bottom of the page for after you enter the campus.

After you turn into the Wesley Woods campus, take an immediate RIGHT (do not go over the bridge). Go past two round buildings on the left (Wesley Woods Towers). Go through the Budd Terrace parking lot (Budd Terrace building on your right) and turn LEFT and then RIGHT at the stop sign. Continue to the five-story white and blue Health Center straight ahead. The Geriatric Psychiatric Clinic/Registration is on the 4th floor.