



**EMORY EYE CENTER
DEPARTMENT OF CONTACT LENS
REFERRAL FORM**

URGENT? YES NO

PATIENT NAME: _____ **DOB:** _____

ADDRESS: _____

PHONE NUMBER(S): _____

REFERRED TO (PLEASE CIRCLE ONE):

First Available

Marisa Feliciano OD

Denh C. Tuyen OD

DIAGNOSIS: _____

**REFERRING PROVIDER
NAME & SPECIALTY:** _____

PHONE & FAX NUMBER: _____

PLEASE FAX RECORDS TO (404)778-5823.

**PLEASE HAVE REFERRING OFFICE/ PARENT/PATIENT CALL (404)778-2020 TO REGISTER
PATIENT'S DEMOGRAPHIC INFORMATION.**

**IF AN URGENT APPOINTMENT IS BEING REQUESTED, PLEASE MARK NOTES URGENT, FAX NOTES, AND
CALL 404-778-2020. THE REFERRING PROVIDER'S OFFICE OR PATIENT WILL BE CONTACTED AFTER
NOTES ARE REVIEWED BY THE PROVIDER.**

THANK YOU FOR CHOOSING EMORY!