

**Emory Eye Center  
Department of Cornea, External Disease, & Refractive Surgery  
Referral Form**

Urgent? YES NO

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Phone Number(s): \_\_\_\_\_

**REFERRED TO (PLEASE CIRCLE ONE):**

First Available  
Dr. Soroosh Behshad  
Dr. Joung (John) Kim

Dr. Priyanka Sood  
Dr. Praneetha Thulasi

Diagnosis: \_\_\_\_\_

Referring Provider  
Name & Specialty: \_\_\_\_\_

Phone & Fax: \_\_\_\_\_

Please fax records (including Lab Test Results), along with this cover sheet to  
(404) 778-2244.

Please ensure that the patient brings a disc containing imaging to the scheduled  
appointment, if applicable.

**Please have referring office/parent/patient call (404) 778-2020 to register the  
patient's demographic information.**

**If an urgent appointment is being requested, please mark notes as urgent, fax  
the notes to (404) 778-2244, and call (404) 778-2020. The referring provider's  
office will be contacted after notes are reviewed by a physician.**

**Thank you for choosing Emory!**