EMORY
HEALTHCARE

EMORY EYE CENTER
DEPARTMENT OF LOW VISION SERVICES
REFERRAL FORM

URGENT? YES NO

PATIENT NAME: _____ **DOB:** _____

ADDRESS: _____

_____

PHONE NUMBER(S): _____

REFERRED TO (PLEASE CIRCLE ONE):

First Available

Susan Primo OD, MPH, FAAO

Kenneth Rosengren OD, FAAO

DIAGNOSIS: _____

REFERRING PROVIDER
NAME & SPECIALTY: _____

PHONE & FAX NUMBER: _____

PLEASE FAX RECORDS, ALONG WITH THIS COVER SHEET, TO (404)778-5609.

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 A CLINICIAN.

THANK YOU FOR CHOOSING EMORY!