



**EMORY EYE CENTER
DEPARTMENT OF OCULAR ONCOLOGY & PATHOLOGY
REFERRAL FORM**

URGENT? YES NO

PATIENT NAME: _____ **DOB:** _____

ADDRESS: _____

PHONE NUMBER(S): _____

REFERRED TO (PLEASE CIRCLE ONE):

First Available

Dr. Hans Grossniklaus

Dr. Jill Wells

DIAGNOSIS: _____

**REFERRING PROVIDER
NAME & SPECIALTY:** _____

PHONE & FAX NUMBER: _____

PLEASE FAX RECORDS AND LABS (IF APPLICABLE) ALONG WITH THIS COVER SHEET.
RECORDS FOR DR. GROSSNIKLAUS SHOULD BE FAXED TO (404)778-4610.
RECORDS FOR DR. WELLS SHOULD BE FAXED TO (404)778-2244.

PLEASE ENSURE THAT PATIENT BRINGS A DISC CONTAINING IMAGING TO SCHEDULED APPOINTMENT.

**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 PHYSICIAN.**

THANK YOU FOR CHOOSING EMORY!