EMORY
HEALTHCARE

EMORY EYE CENTER
DEPARTMENT OF GLAUCOMA OPHTHALMOLOGY
REFERRAL FORM

PATIENT NAME: _____ **DOB:** _____

ADDRESS: _____

_____

PHONE NUMBER(S): _____

REFERRED TO (PLEASE CIRCLE ONE):

First Available

Dr. Allen Beck (Pediatrics)

Dr. Annette Giangiacomo (Pediatrics & Adults)

Dr. Anastasios Costarides (Adults)

Dr. Jeremy Jones (Adults)

DIAGNOSIS: _____

REFERRING PROVIDER
NAME & SPECIALTY: _____

PHONE & FAX NUMBER: _____

PLEASE FAX RECORDS AND LABS (IF APPLICABLE), ALONG WITH THIS COVER SHEET, TO (404)778-4350.

PLEASE ENSURE THAT PATIENT BRINGS A DISC CONTAINING IMAGING AT SCHEDULED APPOINTMENT, IF APPLICABLE.

INITIAL PATIENT EVALUATIONS ARE SCHEDULED WITH A HUMPHREY VISUAL FIELD (HVF) TEST PRIOR TO THE APPOINTMENT UNLESS OTHERWISE SPECIFIED.

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

PLEASE HAVE REFERRING OFFICE/ PARENT/PATIENT CALL (404)778-2020 TO REGISTER PATIENT AND SCHEDULE APPOINTMENT.

THANK YOU FOR CHOOSING EMORY!