EMORY
HEALTHCARE

EMORY EYE CENTER
DEPARTMENT OF INHERITED RETINAL DISEASES
REFERRAL FORM

PATIENT NAME: _____ **DOB:** _____

ADDRESS: _____

_____

PHONE NUMBER(S): _____

REFERRED TO (PLEASE CIRCLE ONE):

First Available

Dr. Nieraj Jain Dr. Jiong Yan

DIAGNOSIS: _____

REFERRING PROVIDER
NAME & SPECIALTY: _____

PHONE & FAX NUMBER: _____

PLEASE FAX RECORDS AND LABS (IF APPLICABLE), ALONG WITH THIS COVER SHEET, TO (404)778-4380.

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

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.

A SERIES OF TESTS MAY BE SCHEDULED ON A DATE PRIOR TO OR ON THE SAME DAY AS THE INITIAL CONSULTATION UNLESS OTHERWISE NOTED.

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

THANK YOU FOR CHOOSING EMORY!