



**EMORY EYE CENTER  
DEPARTMENT OF NEURO-OPHTHALMOLOGY  
REFERRAL FORM**

**PATIENT NAME:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_  
\_\_\_\_\_

**PHONE NUMBER(S):** \_\_\_\_\_

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

First Available

Dr. Valerie Biousse

Dr. Nancy Newman

Dr. Kannan Narayana

Dr. Jason Peragallo

**DIAGNOSIS:** \_\_\_\_\_

**REFERRING PROVIDER  
NAME & SPECIALTY:** \_\_\_\_\_

**PHONE & FAX NUMBER:** \_\_\_\_\_

PLEASE FAX RECORDS AND LABS (IF APPLICABLE), ALONG WITH THIS COVER SHEET, TO (404)778-4849.  
PLEASE FAX NOTES FOR DR. NARAYANA TO (404)686-4785.

PLEASE ENSURE THAT PATIENT BRINGS A DISC CONTAINING IMAGING TO 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.**

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

***THANK YOU FOR CHOOSING EMORY!***