EMORY EYE CENTER

DEPARTMENT OF OCULOPLASTIC SURGERY

REFERRAL FORM

PATIENT NAME: ____ **DOB:** ____________________

ADDRESS: ____

____

PHONE NUMBER(S): ____

REFERRED TO (PLEASE CIRCLE ONE):

First Available

Dr. Brent Hayek — Dr. Hee Kim

Dr. Denise Kim — Dr. Ted Wojno

DIAGNOSIS: ____

REFERRING PROVIDER
NAME & SPECIALTY: ____

PHONE & FAX NUMBER: ____

PLEASE FAX RECORDS AND LABS (IF APPLICABLE), ALONG WITH THIS COVER SHEET, TO (404)778-4415.

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

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!