



**EMORY EYE CENTER
DEPARTMENT OF PEDIATRIC OPHTHALMOLOGY & ADULT STRABISMUS
REFERRAL FORM**

PATIENT NAME: _____ **DOB:** _____

ADDRESS: _____

PARENT/GUARDIAN NAME AND PHONE NUMBER(S): _____

REFERRED TO (PLEASE CIRCLE ONE):

- | | |
|--------------------|-------------------------------------|
| First Available | Dr. Sheryl Menacker (special needs) |
| Dr. Amy Hutchinson | Dr. Jason Peragallo (neuro) |
| Dr. Scott Lambert | Dr. Suma Shankar (genetics) |
| Dr. Phoebe Lenhart | Dr. Natalie Weil |

DIAGNOSIS: _____

**REFERRING PROVIDER
NAME & SPECIALTY:** _____

PHONE & FAX NUMBER: _____

PLEASE FAX RECORDS AND LABS (IF APPLICABLE), ALONG WITH THIS COVER SHEET, TO (404)778-5203.

PLEASE ENSURE THAT PATIENT BRINGS A DISC CONTAINING IMAGING TO 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!