EMORY
HEALTHCARE

EMORY EYE CENTER
DEPARTMENT OF UVEITIS & VASCULITIS
REFERRAL FORM

PATIENT NAME: _____ **DOB:** _____

ADDRESS: _____

_____

PHONE NUMBER(S): _____

REFERRED TO (PLEASE CIRCLE ONE):

First Available Dr. Purnima Patel

Dr. Ghazala O'Keefe Dr. Steven Yeh

DIAGNOSIS: _____

REFERRING PROVIDER
NAME & SPECIALTY: _____

PHONE & FAX NUMBER: _____

PLEASE FAX RECORDS (INCLUDING **LAB TEST RESULTS),** ALONG WITH THIS COVER SHEET, TO (404)778-4380.

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!