

EMORY EYE CENTER DEPARTMENT OF LOW VISION SERVICES REFERRAL FORM

URGENT? YES NO		
PATIENT NAME:		_DOB:
ADDRESS:		
	REFERRED TO (PLEASE CIRCLE ONE):	
	First Available	
Susan Primo OD, MPH, FAAO		Kenneth Rosengren OD, FAAC
DIAGNOSIS:		
REFERRING PROVIDER NAME & SPECIALTY:		
PHONE & FAX NUMBER:		

PLEASE FAX RECORDS, ALONG WITH THIS COVER SHEET, TO (404)778-5609.

PLEASE HAVE REFERRING OFFICE/ PARENT/PATIENT CALL (404)778-2020 TO REGISTER PATIENT'S DEMOGRAPHIC INFORMATION.

IF AN URGENT APPOINTMENT IS BEING REQUESTED, PLEASE MARK NOTES URGENT, FAX NOTES, AND CALL 404-778-2020. THE REFERRING PROVIDER'S OFFICE OR PATIENT WILL BE CONTACTED AFTER NOTES ARE REVIEWED BY A CLINICIAN.

THANK YOU FOR CHOOSING EMORY!