

Low Vision Referral Form

Please download this form, have your referring provider fill it out, and then ask them to fax it to **404-778-5609** before your scheduled visit at the Emory Eye Center.

**Incomplete referral forms will not be processed.*

Appointment Status (check one): ☐ Urgent ☐ First available

Diagnosis:

Reason for visit:

**Receiving clinician
(circle one):**

Susan Primo, OD

Kenneth Rosengren,
OD

Trenton Gaasch, OD

Patient's Name: _____ DOB: _____

Patient's Address: _____

Patient's Phone #: _____ SSN: _____

Insurance: _____ ID#: _____

Guarantor: _____ Guarantor's DOB: _____

Referring Clinician: _____ Specialty: _____

Referring Practice: _____

Referring Clinician's Phone #: _____ Fax #: _____

Primary Care Provider: _____



EMORY
EYE CENTER

Next steps to schedule an appointment:

For Providers:

1. Register your patient: call 404-778-2020 to share your patient's details
2. Fax the following items to **404-778-5609**
 - ☐ The referral form **Incomplete forms will not be processed*
 - ☐ All medical records, including diagnostic testing, X-rays, CTs, MRIs, Humphrey or Goldman Visual Field results and any lab test results
 - ☐ The disc containing patient's images via Powershare or in physical copy

For Patients:

1. Bring your ID, insurance card and office co-pay (if necessary)

Thank you for choosing
Emory Eye Center