



EMORY EYE CENTER
DEPARTMENT OF VITREORETINAL (RETINA) SURGERY AND DISEASES
REFERRAL FORM

URGENT? YES NO

PATIENT NAME: _____ DOB: _____

ADDRESS: _____

PHONE NUMBER(S): _____

REFERRED TO (PLEASE CIRCLE ONE):

First Available

Dr. Blaine Cribbs (medical/surgical)

Dr. Ghazala O'Keefe (medical)

Dr. Andrew Hendrick (medical/surgical)

Dr. Purnima Patel (medical)

Dr. G. Baker Hubbard III (medical/surgical)

Dr. Jiong Yan (medical/surgical)

Dr. Nieraj Jain (medical/surgical)

Dr. Steven Yeh (medical/surgical)

DIAGNOSIS: _____

REFERRING PROVIDER
NAME & SPECIALTY: _____

PHONE & FAX NUMBER: _____

PLEASE FAX RECORDS AND LABS (IF APPLICABLE), ALONG WITH THIS COVER SHEET, TO (404)778-4380.

PLEASE ENSURE THAT PATIENT BRINGS A DISC (IF APPLICABLE) CONTAINING IMAGING TO SCHEDULED APPOINTMENT.

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 PHYSICIAN.

THANK YOU FOR CHOOSING EMORY!