# Emory Cardiothoracic Surgery

## Physician Referral Form  Fax To: 404-727-2810

**Thank you for referring your patient to Emory Cardiothoracic Surgery. Please indicate the location preference for your patient:**

O **First available, any location**

O **Emory University Hospital**
1365 Clifton Rd NE, Suite 2223
Atlanta, GA 30322
Scheduling Line 404-778-5040

O Specific Surgeon _____

O **Emory University Hospital Midtown**
550 Peachtree St NE, 6th Floor
Atlanta, GA 30308
Scheduling Line 404-686-2513

O Specific Surgeon _____

O **Emory Saint Joseph's Hospital**
5665 Peachtree Dunwoody Rd
Atlanta, GA 30342
Scheduling Line 404-778-7200

O Specific Surgeon _____

O **Emory Clinic at Columbus St. Francis Hospital**
2300 Manchester Expy
Columbus, GA 31904
Scheduling Line 706-596-8200

O Specific Surgeon _____

**Patient information**

Patient name: DOB: O M O F

Street Address:

City, state:

Please check preferred contact phone number:

O HOME: O CELL:

Interpreter needed? OYES ONO Language:

Primary Care Provider (if different from referring):

Patient's medical issue

**Diagnosis code**:

Reason for referral/patient symptoms:

Medical records to send (all that apply):

O Patient Demographic Sheet
O X-Rays
OMRI/MRA
O Last Office Note
O CT Scan
O Diagnostic Testing (send disc)

**Referring provider information**

Name: Clinic:

City, state: Phone no.:

Fax: Email:

Office contact:

***For emergencies or to transfer your patient to an Emory hospital, please call 404-778-4930.**

For more information please go to www.emoryhealthcare.org/rightdirection.