

Tel: **404-778-4832**
Fax: **404-778-6022**

Thank you for referring your patient to Emory Healthcare. Please indicate the specialty to which you are referring your patient:

- Allergy and Immunology
- Arthritis and Rheumatology
- Bariatric Surgery
- Cardiology
- Cardiothoracic Surgery
- Dermatology
- Endocrinology
- Gastroenterology
- General Surgery
- Genetic Medicine
- Gerontology
- Hematology Oncology
- Infectious Disease
- Interventional Radiology
- Medical Oncology
- Nephrology
- Neurology
- Neurosurgery
- OB/GYN
- Ophthalmology
- Oral and Maxillofacial Surgery
- Orthopaedics & Spine
- Otolaryngology
- Pain Center
- Palliative Medicine
- Plastic and Reconstructive Surgery
- Psychiatry
- Pulmonary Care
- Radiation Oncology
- Rehabilitation Services
- Sleep Disorders
- Sports Medicine
- Surgical Oncology
- Transplant
- Urologic Surgery
- Vascular Surgery
- Other _____
- Specific physician _____

Please provide the following so we can schedule an appointment:	FAX THIS FORM AND PERTINENT MEDICAL RECORDS TO 404-778-6022
<input type="checkbox"/> PERTINENT MEDICAL RECORDS <input type="checkbox"/> INSURANCE AUTHORIZATION (IF REQUIRED)	
Referring provider information	
Name:	Practice:
City, state:	Phone:
Fax:	E-mail:
Office contact:	
Patient information	
Patient name:	O M O F
Street address:	
City, state:	Date of birth:
Parent/guardian:	
Please check preferred contact phone number:	
<input type="checkbox"/> HOME:	<input type="checkbox"/> CELL:
<input type="checkbox"/> WORK:	
Interpreter needed? <input type="checkbox"/> YES <input type="checkbox"/> NO LANGUAGE:	
Primary Care Provider (IF DIFFERENT FROM REFERRING):	
This visit is (MARK ONE):	
<input type="checkbox"/> Routine WITHIN 30 DAYS <input type="checkbox"/> Semi-urgent *WITHIN 2 WEEKS <input type="checkbox"/> Urgent *LESS THAN 48 HOURS	
*For urgent appointments, please call 404-778-4832	
I am requesting: <input type="checkbox"/> CONSULT ONLY <input type="checkbox"/> ONGOING CARE <input type="checkbox"/> REFERRAL REQUESTED BY PATIENT	
Patient's medical issue	
ICD-10 code:	
Please tell us what specific medical issue to address at this visit:	
Information check list PLEASE ATTACH (WHERE APPLICABLE):	
<input type="checkbox"/> PROGRESS NOTES	<input type="checkbox"/> PREVIOUS WORK UP FOR THESE SYMPTOMS
<input type="checkbox"/> LABS	<input type="checkbox"/> PATHOLOGY
<input type="checkbox"/> IMAGING	<input type="checkbox"/> MEDICATION LIST, ALLERGIES
<input type="checkbox"/> OTHER:	
QUESTIONS ABOUT THIS REFERRAL? CALL US AT 404-778-4832.	