



**EMORY EYE CENTER  
DEPARTMENT OF INHERITED RETINAL DISEASES  
REFERRAL FORM**

**PATIENT NAME:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_  
\_\_\_\_\_

**PHONE NUMBER(S):** \_\_\_\_\_

**REFERRED TO (PLEASE CIRCLE ONE):**

First Available

Dr. Nieraj Jain

Dr. Jiong Yan

**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 AT SCHEDULED APPOINTMENT.

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

**A SERIES OF TESTS MAY BE SCHEDULED ON A DATE PRIOR TO OR ON THE SAME DAY AS THE INITIAL CONSULTATION UNLESS OTHERWISE NOTED.**

**PLEASE HAVE REFERRING OFFICE/ PARENT/PATIENT CALL (404)778-2020 TO REGISTER PATIENT AND SCHEDULE APPOINTMENT.**

***THANK YOU FOR CHOOSING EMORY!***