

## EMORY EYE CENTER DEPARTMENT OF OCULOPLASTIC SURGERY REFERRAL FORM

PATIENT NAME:	DOB:
ADDRESS:	
REFERRE	ED TO (PLEASE CIRCLE ONE):
	First Available
Dr. Brent Hayek	Dr. Hee Kim
Dr. Denise Kim	Dr. Ted Wojno
DIAGNOSIS:	
REFERRING PROVIDER NAME & SPECIALTY:	
PHONE & FAX NUMBER:	
PLEASE FAX RECORDS AND LABS (IF APPLI	CABLE), ALONG WITH THIS COVER SHEET, TO (404)778-4415.
PLEASE ENSURE THAT PATIENT BRINGS A	DISC 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.

IF APPLICABLE.

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

THANK YOU FOR CHOOSING EMORY!