EMORY
HEALTHCARE

EMORY EYE CENTER
DEPARTMENT OF PEDIATRIC OPHTHALMOLOGY & ADULT STRABISMUS
REFERRAL FORM

PATIENT NAME: _____ **DOB:** _____

ADDRESS: _____

_____

PARENT/GUARDIAN NAME AND PHONE NUMBER(S): _____

REFERRED TO (PLEASE CIRCLE ONE):

First Available

Dr. Amy Hutchinson

Dr. Scott Lambert

Dr. Phoebe Lenhart

Dr. Sheryl Menacker (special needs)

Dr. Jason Peragallo (neuro)

Dr. Suma Shankar (genetics)

Dr. Natalie Weil

DIAGNOSIS: _____

REFERRING PROVIDER
NAME & SPECIALTY: _____

PHONE & FAX NUMBER: _____

PLEASE FAX RECORDS AND LABS (IF APPLICABLE), ALONG WITH THIS COVER SHEET, TO (404)778-5203.

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

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.

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

THANK YOU FOR CHOOSING EMORY!