EMORY HEALTHCARE

EMORY EYE CENTER

**Emory Eye Center**
**Department of Oculoplastic Surgery**
**Referral Form**

**Urgent? YES NO**

**Patient Name: _____DOB:_____**

**Address**:_____

_____

**Phone Number(s):**_____

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

First Available
Dr. Adam de la Garza
Dr. Hee Joon Kim
Dr. Ted Wojno

**Diagnosis:**_____

**Referring Provider Name & Specialty:**_____

**Phone & Fax**:_____

Please fax records (including Lab Test Results), along with this cover sheet to (404) 778-4415.

Please ensure that the patient brings a disc containing imaging to the scheduled appointment, if applicable.

**Please have referring office/parent/patient call (404) 778-2020 to register the patient's demographic information.**

**If an urgent appointment is being requested,** please mark notes as urgent, fax the notes to (404) 778-4415, and call (404) 778-2020. The referring provider's office will be contacted after notes are reviewed by a physician.

## Thank you for choosing Emory!