



**Emory Eye Center
Department Ophthalmology – Glaucoma Section
Referral Form**

Urgent? YES NO

Patient Name: _____ **DOB:** _____

Address: _____

Phone Number(s): _____

REFERRED TO (PLEASE CIRCLE ONE):

First Available

Dr. Deepta Ghate (Pediatrics & Adults)

Dr. Allen Beck (Pediatrics & Adults)

Dr. Jeremy Jones (Adults)

Dr. Anastasios Costarides (Adults)

Dr. Farah O. Gulaid OD(Adults)

Diagnosis: _____

**Referring Provider
Name & Specialty:** _____

Phone & Fax: _____

Please **fax records** (including Lab Test Results if applicable), along with this cover sheet to
(404) 778-6581.

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

Initial patient evaluations are scheduled with a Humphrey Visual Field (HVF) test prior to the appointment unless otherwise specified.

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

If an urgent appointment is being requested, please mark notes as urgent, fax the notes to (404) 778-6581, 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!