EMORY
EYE CENTER

DEPARTMENT OF NEURO-OPHTHALMOLOGY
Referral Form

Patient Name: _____ DOB: _____

Address: _____

Phone: _____

REFERRED TO (PLEASE CIRCLE ONE):
First Available / Urgent

Dr. Nancy Newman

Dr. Valerie Biousse

Dr. Michael Dattilo

Dr. Jason Peragallo

Dr. Sachin Kedar

Diagnosis: _____

Referring provider
Name & Specialty: _____

Phone & Fax Number: _____

Please fax records and labs (If applicable), along with this cover sheet, to 404-778-4849.

Please ensure that patient brings a DISC containing Imaging to 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 the notes are reviewed by a physician.

Please have referring office/parent/patient call 404-778-2020 to register and schedule appointment.

THANK YOU FOR CHOOSING EMORY!