Low Vision Referral Form

Please download this form, have your referring provider fill it out, and then ask them to fax it to ***404-778-5908*** *before your scheduled visit at the Emory Eye Center.*

**Incomplete referral forms will not be processed.*

Appointment Status (check one): ☐ Urgent ☐ First available

Receiving clinician (circle one):

Susan Primo, OD

Kenneth Rosengren, OD

Trenton Gaasch, OD

Diagnosis:

Reason for visit:

Patient's Name: _____ DOB: _____

Patient's Address: _____

Patient's Phone #:_____ SSN:_____

Insurance: _____ ID#:_____

Guarantor: _____ Guarantor's DOB: _____

Referring Clinician: _____ Specialty: _____

Referring Practice: _____

Referring Clinician's Phone #:_____ Fax #:_____

Primary Care Provider: _____

EMORY
EYE CENTER

Next steps to schedule an appointment:

For Providers:

1. Register your patient: call 404-778-2020 to share your patient's details

2. Fax the following items to 404-778-5908

   ☐ The referral form **Incomplete forms will not be processed*

   ☐ All medical records, including diagnostic testing, X-rays, CTs, MRIs, Humphrey or Goldman Visual Field results and any lab test results

   ☐ The disc containing patient's images via Powershare or in physical copy

For Patients:

1. Bring your ID, insurance card and office co-pay (if necessary)

Thank you for choosing

Emory Eye Center

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