EMORY HEALTHCARE

Physician Referral Form

Tel: **404-778-4832**
Fax: **404-778-6022**

Thank you for referring your patient to Emory Healthcare. Please indicate the specialty to which you are referring your patient:

- (•) Allergy and Immunology
- ( ) Arthritis and Rheumatology
- ( ) Bariatric Surgery
- ( ) Cardiology
- ( ) Cardiothoracic Surgery
- ( ) Dermatology
- ( ) Endocrinology
- ( ) Gastroenterology
- ( ) General Surgery
- ( ) Genetic Medicine
- ( ) Gerontology
- ( ) Hematology Oncology
- ( ) Infectious Disease
- ( ) Interventional Radiology
- ( ) Medical Oncology
- ( ) Nephrology
- ( ) Neurology
- ( ) Neurosurgery
- ( ) OB/GYN
- ( ) Ophthalmology
- ( ) Oral and Maxillofacial Surgery
- ( ) Orthopaedics & Spine
- ( ) Otolaryngology
- ( ) Pain Center
- ( ) Palliative Medicine
- ( ) Plastic and Reconstructive Surgery
- ( ) Psychiatry
- ( ) Pulmonary Care
- ( ) Radiation Oncology
- ( ) Rehabilitation Services
- ( ) Sleep Disorders
- ( ) Sports Medicine
- ( ) Surgical Oncology
- ( ) Transplant
- ( ) Urologic Surgery
- ( ) Vascular Surgery
- ( ) Other_____
- [ ] Specific physician_____

Please provide the following so we can schedule an appointment:

FAX THIS FORM AND PERTINENT MEDICAL RECORDS TO 404-778-6022

⊘ PERTINENT MEDICAL RECORDS

[O] INSURANCE AUTHORIZATION (IF REQUIRED)

Referring provider information

Name: Dr Test	Practice:
City, state:	Phone:
Fax:	E-mail:
Office contact:	

Patient information

Patient name: Chester Tester (•) M ( ) F

Street address: 123

City, state: atlanta ga Date of birth: 1979-03-17

Parent/guardian:

Please check preferred contact phone number:

[O] HOME: [O] CELL: [O] WORK:

Interpreter needed? ( ) YES ( ) NO LANGUAGE:

Primary Care Provider (IF DIFFERENT FROM REFERRING):

This visit is (MARK ONE):

( ) **Routine** WITHIN 30 DAYS ( ) **Semi-urgent** *WITHIN 2 WEEKS ( ) **Urgent** *LESS THAN 48 HOURS

*For urgent appointments, please call **404-778-4832**

I am requesting: [O] CONSULT ONLY [O] ONGOING CARE [O] REFERRAL REQUESTED BY PATIENT

Patient's medical issue

ICD-10 code:

Please tell us what specific medical issue to address at this visit:

Information check list PLEASE ATTACH (WHERE APPLICABLE):

[O] PROGRESS NOTES	[O] PREVIOUS WORK UP FOR THESE SYMPTOMS
[O] LABS	[O] PATHOLOGY
[O] IMAGING	[O] MEDICATION LIST, ALLERGIES
[O] OTHER:	

QUESTIONS ABOUT THIS REFERRAL? CALL US AT 404-778-4832.