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Referring Practice:

Practice Name _____
Referring Provider _____
Address _____
Telephone Number _____
Fax Number _____

Patient Details:

Name _____
Date of Birth _____
Address _____
Telephone number _____
Is an interpreter needed? Yes / No If yes, which language? _____

Reason For Visit:

_____
_____
_____
_____

Practice Referred to:

Joli Oculoplastics
Physician: Julia Kang, MD
Address: 10710 Medlock Bridge Rd., STE 150, Johns Creek, GA 30097
Telephone: 770-629-0600
Fax: 770-215-7522
Email: info@jolioculoplastics.com

Appointment:

Date _____ Time _____

Client Authorization for Referral:

I authorize my case to be referred to the above practice.

Please fax or e-mail this form and most recent exam note to: info@jolioculoplastics.com