Cleveland Sight Center

REFERRAL TO CLEVELAND SIGHT CENTER LOW VISION CLINIC

(use this fax cover sheet as the referral)

Fax : (216) 658-8731 Low Vision Clinic

Please fax your most recent comprehensive eye exam notes (EMR or paper) with all *ICD-10 CODES (important)*.

Please include most recent visual field results if relevant to patient's condition.

To: Low Vision Clinic **Fax:** (216) 658-8731

Questions: Contact Barb Piascik **Phone:** (216) 658-4670

From: _____

Subject: Referral

Number of pages: _____

Optional additional information/requests: _____

_____

_____

THANK YOU! We look forward to participating in the care of your patient.

(HIPAA Privacy Rule 45 CFR 164.506 permits disclosure of PHI)

Patient Name: _____ Phone: _____