Cleveland Sight Center
Since 1906, A Partner for Life

LOW VISION CLINIC

1909 E. 101st Street
Cleveland, OH 44106
PH: 216-658-8737 FAX: 216-658-8731
www.clevelandsightcenter.org

REFERRAL FORM

Patient Name: _____D.O.B._____

Address: _____CITY_____ZIP_____

Home Phone:_____ Cell Phone:_____

VA: OD:_____OS: _____

DX: OD:_____OS: _____

Reason for referral:

___Low vision exam
___Goldmann Visual Fields
___Prism evaluation
___Employment services
___Orientation and Mobility
___Other Services _____

Referring Physician Signature:_____

Date of last exam:_____

Name of Practice:_____

Address:_____

Phone: _____ FAX:_____

Please fax referral and exam notes from last visit to **Low Vision Clinic** at **216-658-8731** so we can schedule an appointment for the patient.