Cleveland Sight Center
1909 East 101st Street
Cleveland, OH 44106
216-791-8118

REFERRAL FORM FOR ADULTS

Please attach your most recent eye exam notes and fax the completed referrals to 216-658-8731

DATE:_____

PATIENT INFORMATION: Name: _____Date of Birth: _____

Telephone number: _____ Address: _____

MEDICAL INFORMATION: Date of Patient's last visit: _____

Primary Dx OD: _____ ICD-10 Code: _____

_____

Primary Dx OS: _____ ICD-10 Code: _____

_____

Secondary DX OD:_____ ICD-10 Code: _____

_____

Secondary DX OS:_____ ICD-10 Code: _____

_____

Visual Acuity (Check one: _____ with correction: _____ without correction):

	Far	Near
Right Eye:	____	____
Left Eye:	____	____

Is the patient's condition Stable or Progressive? _____

Are there any other health issues? _____

Visual Fields: Please include the most recent visual fields results

ADDITIONAL REMARKS: _____

_____

Doctor's Signature: _____ Printed Name: _____

Phone: _____ Fax: _____ Address: _____

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