Cleveland Sight Center
University Circle
1909 East 101st Street
Cleveland, OH 44106
216-791-8118
clevelandsightcenter.org

Cleveland Sight Center Referral Form

Please attach your most recent eye exam notes and fax the completed referrals to 216-791-1101.

PATIENT INFORMATION

Date of Referral: _____ Date of Birth: _____

Patient's Name: _____ Telephone number: _____

Patient's address: _____

MEDICAL INFORMATION

Date of Patient's last visit: _____

Primary Diagnosis: _____ Date of onset: _____

Secondary Diagnosis: _____ Date of onset: _____

Primary O.D. _____ O.S. _____

Secondary O.D. _____ O.S. _____

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

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

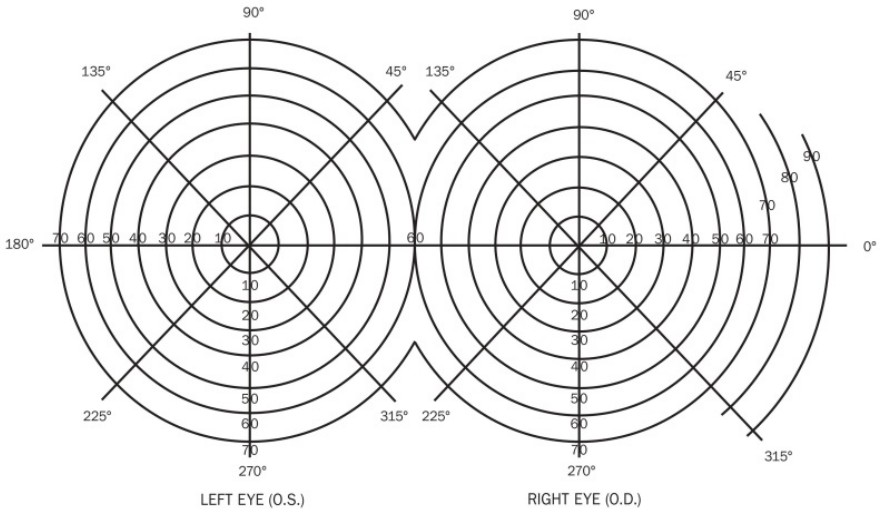
Visual Fields: Please attach the most recent visual fields results

Is the patient legally blind?: _____

Is the patient's condition Stable or Progressive?: _____

Has an Occupational Therapy Assessment been completed?: _____

Figure 1:



MEDICAL BILLING INFORMATION

Patient's Insurance Carrier: _____

Insurance Number: _____

Examining Doctor's Medicare UPI # : _____

ICD-10 Codes used (1 + 2): _____

SERVICES SUGGESTED:

____ Occupational Therapy (a referral from the referring doctor must be sent for this service)

____ Social Work ____ Low Vision Clinic Appointment

____ Employment Services ____ Orientation and Mobility Services

____ Independent Living Services (55 years and older)

____ Counseling (TLC or Share The Vision)

ADDITIONAL REMARKS: _____

_____

_____

Referring Doctor's Signature: _____

Referring Doctor's Printed Name: _____

Date: _____

Address: _____