****

**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 Leah Tater **Phone:** (216) 658-8732

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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_