



**LOW VISION CLINIC**  
**1909 E. 101<sup>st</sup> 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:**

- |   |   |
|---|---|
| <input type="checkbox"/> Low vision exam        | <input type="checkbox"/> Employment services      |
| <input type="checkbox"/> Goldmann Visual Fields | <input type="checkbox"/> Orientation and Mobility |
| <input type="checkbox"/> Prism evaluation       | <input type="checkbox"/> 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.

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