



## REFERRAL TO CLEVELAND SIGHT CENTER CLINIC

*(use this fax cover sheet as the referral)*

**Fax : (216) 920-6280**

Please fax most recent medical insurance information, 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:** Cleveland Sight Center Clinic

**Fax:** (216) 920-6280

**Please complete the below information:**

From: \_\_\_\_\_

Subject: Referral

Number of pages: \_\_\_\_\_

Return Fax Number: \_\_\_\_\_

Optional additional information/requests: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

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

Patient Name: \_\_\_\_\_ Phone: \_\_\_\_\_

**THANK YOU! We look forward to participating in the care of your patient.**

**Questions? Contact Holly Amirault at (216) 658-8732**