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: _________________________________

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(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 Cleveland Sight Center at (216) 658-8732