**OHIO LIONS DISTRICT OH-2**

**Vision Clinic Referral Form**

Club Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referral Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Billing Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Services Requested/Authorized:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_Exam($20)

\_\_\_\_\_Glasses($50)

\_\_\_\_\_Other(Specify)\*

\*If a follow up exam is required to diagnose glaucoma, macular degeneration or other serious underlying condition, an additional $20.00 fee will be billed)

**Patient Information**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *I give permission for Lions Clubs*

Parent/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *and LCHD to communicate*

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *regarding payment for these*

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *services.*

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Lions Club Authorizing Individual**

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fax this form to: 440.240.1663 or Mail to:

Lorain County Health and Dentistry

1205 Broadway

Lorain, Ohio 44052

Attn: Call Center Lead