OHIO LIONS DISTRICT OH-2
Vision Clinic Referral Form

Club Name _____

Billing Address _____

_____

Referral Date _____

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: _____

Parent/Guardian: _____

Phone: _____

Phone: _____

Address: _____

I give permission for Lions Clubs and LCHD to communicate regarding payment for these services.

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

Rev. 5/2016