



OHIO LIONS DISTRICT 13B/OH2 Vision Clinic Referral Form

Club Name _____

Referral Date _____

Billing Address _____

Services Requested/Authorized:

_____ Exam(\$20)

_____ Glasses(\$42)

_____ Other(Specify)

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