Patient Referral Form

TO: **THE CORRECTIVE EYE CENTER**

Dr's Samuel Salamon, Gregory Louis & Jack Peretz

FROM: _____ **O.D.**____ **M.D.** ____ **Urgent Care**_____

Office Locations:

Euclid Medical Plaza
26300 Euclid Ave. #312
Euclid, Ohio 44132

Rockside Medical Center
6701 Rockside Rd #300
Independence, Ohio 44131

St. Vincent Medical Building
2322 East 22nd St. #307
Cleveland, Ohio 44115

Western Reserve Eye Care
3100 Wooster Rd.
Rocky River, Ohio 44116

To schedule an appointment for any office call:

216-574-8900 or fax form to: 216-325-0352

Monday thru Friday 8:00AM to 4:30PM

PATIENT NAME_____ **Date of Birth**_____

Address_____

City_____**State**_____**Zip**_____

Phone_____

REASON FOR REFERAL:

- ☐ **CATARACT** ☐ **OD** ☐ **OS** ☐ **OU**
- ☐ **GLAUCOMA**
- ☐ **VISUAL DISTURBANCE**
- ☐ **CHALAZION**
- ☐ **DRY EYE**
- ☐ **OCULAR INFLAMMATION**
- ☐ **PLAQUENIL**
- ☐ **DIABETES**
- ☐ **OTHER (PLEASE DETAIL)**

TESTING REQUESTED:

- ☐ **Visual Field**
- ☐ **OCT**
- ☐ **SLT**
- ☐ **Photos**

Dr. Signature_____**Date**_____

Patient Statement: The reason I am being referred to another doctor has been discussed with me. I understand that it is my responsibility to make an appointment with the referred doctor. I grant permission for the above named doctors to exchange information from my case.

Patients Signature_____**Date**_____