



Tri-State
 Memorial Hospital &
 Medical Campus

REFERRAL FORM
TRI-STATE GENERAL SURGERY
LEROY SMITH, MD
ERIC L. THOMAS, MD, FACS
BYRON WRIGHT, MD, FACS

1119 Highland Avenue, Suite 4 | Clarkston, WA 99403 | Phone: 509.254.2722 | Fax: 509.769.2022

Patient Information

Date ___/___/___ Patient Name _____ DOB ___/___/___
 Home Phone # _____ Secondary Phone # _____
 Mailing Address _____ City _____
 State/Zip Code _____ Social Security # _____
 Primary Care Provider _____
 Primary Care Phone # _____ Primary Care Fax # _____

Insurance Information

Primary Insurance _____
 Policy/ID # _____ Group # _____
 Secondary Insurance _____
 Policy/ID # _____ Group # _____

Reason for Referral

Brief description of history/symptoms _____

Specific requests (if applicable) _____

Please include the following information with this form:

- N/A Included Allergies and intolerances
- N/A Included Medication list
- N/A Included Recent office notes and notes regarding the issue
- N/A Included History and physical
- N/A Included Diagnostic procedures (x-rays, MRI, CT, labs)
- N/A Included Colonoscopy/EGD

Fax this form and other documents to 509.769.2022. If you need to speak with the office staff, please call 509.254.2722. Once the referral information is received, we will call the patient to schedule. We will also notify your office of the appointment date.