Tri-State
Memorial Hospital &
Medical Campus

REFERRAL FORM

TRI-STATE UROLOGY
KENNETH BERGER, MD
DUNCAN HARRIS, MD

1119 Highland Avenue, Suite 1 | 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.