Tri-State Memorial Hospital & Medical Campus

INFECTIOUS DISEASE
ANUBHAV KANWAR, MD

Referral Form

Date of Referral _____ Referring Provider/Phone _____

Primary Care Provider/Phone _____

Patient Information

Patient Name _____ DOB ___/___/___ Age _____

Home Phone # _____ Secondary Phone # _____

Mailing Address _____ City _____

State/Zip Code _____ Social Security # _____

Insurance Information

Primary Insurance _____

Policy/ID# _____ Group # _____

Secondary Insurance _____

Policy/ID# _____ Group # _____

Work Comp Claim # _____ Carrier _____

Additional Information

Diagnosis/Condition (please give a brief description of symptoms/history): _____

_____

_____

Specific Requests (if applicable) _____

_____

Referring Provider (print name) _____

Authorization # _____

Please include the following information with this form:

N/A ❑ Done ❑ Last office note specifically related to referral (Includes: past medical & surgical history, & current medication & allergies)(Office note to include: if patient has any history of HIV/Hepatitis C/Hepatitis B/MRSA/Infections due to carbapenem-resistant organisms; any antimicrobials gives so far (and the dates give); any work up done so far)

N/A ❑ Done ❑ Radiology reports: any imaging related to diagnosis/conditions

N/A ❑ Done ❑ Labs: any labs completed within the last year

N/A ❑ Done ❑ Demographic information with copy of insurance cards

Please fax this form and other documents to: 509.254.2712

Contact: 1119 Highland Avenue, Suite 6
Clarkston, WA 99403
Phone: 509.2542708
Fax: 509.254.2712