



WOUND HEALING & HYPERBARIC MEDICINE



PODIATRY

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www.TriStateHospital.org

Wound Healing & Hyperbaric Medicine

(Please choose one.)

Podiatry/Foot & Ankle Surgery

REFERRAL FORM

Patient Name _____ DOB _____

SSN _____

Patient Phone # _____

Reason for Referral _____

Primary Care Physician _____

Referring Provider _____

Provider Phone # _____

Provider Fax # _____

PLEASE INCLUDE THE FOLLOWING:

- Demographic information
- Recent office notes (at least last two)
- H & P
- Diagnostic procedures (x-ray, labs, MRI, CT)

In order to process your referral, please complete the entire form and fax it back with the above listed documents to **(509) 758-1140**.

We will contact the patient to schedule an appointment.

FAX: (509) 758-1140