REFERRAL FORM
TRISTATE GENERAL SURGERY
LEROY SMITH, MD
BYRON WRIGHT, MD, FACS

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 ______________________________

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Specific requests (if applicable) ______________________________

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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.

Contact: TriState General Surgery
1119 Highland Avenue, Suite 4
Clarkston, WA 99403
Phone: 509.254.2722
Fax: 509.769.2022