TriState Health

REFERRAL FORM
TRISTATE PULMONOLOGY
KEITH J. POPOVICH, MD
BETH A. MONSEBROTEN, FNP-C
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1119 Highland Avenue, Suite 2 | Clarkston, WA 99403 | Phone: 509.769.2201 | Fax: 509.758.9199

Patient Information

Patient Name _____ DOB ___/___/_____

Home Phone # _____ Secondary Phone # _____

Mailing Address _____ City _____

State/Zip Code _____ Social Security # _____

Referring Provider _____

Insurance Information

Primary Insurance _____

Policy/ID# _____ Group # _____

Secondary Insurance _____

Policy/ID# _____ Group # _____

Reason for Referral (please give a brief description of symptoms/history)

_____

_____

_____

_____

Specific requests (if applicable) _____

_____

Please include the following information with this form:

N/A ❑ Included ❑ **Demographic sheet**
N/A ❑ Included ❑ **Last three chart notes with PCP, cardiology, and oncology**
N/A ❑ Included ❑ **All records from a previous pulmonologist**
N/A ❑ Included ❑ **Labs preformed in the last two years (CMP, CBC, BMP, ABG)**
N/A ❑ Included ❑ **All heart monitor, stress tests, and PFT reports preformed in the last two years**
N/A ❑ Included ❑ **All sleep study reports**
N/A ❑ Included ❑ **Chest imaging (CT or X-RAY) preformed in the last two years**

Fax this form and other documents to 509.758.9199. Once the referral information is accepted, we will call the patient to schedule. We will also notify your office of the appointment date.

IF YOU NEED TO SPEAK WITH OFFICE STAFF REGARDING THIS REFERRAL, PLEASE CALL 509.769.2024.