TriState Health

REFERRAL FORM

TRISTATE WOUND HEALING & HYPERBARIC MEDICINE
VILAS DESPHANDE, MD
BRANDON WHITLOCK, AG-ACNP

TRISTATE PODIATRY
KARL JOHNSON, DPM

1119 Highland Avenue, Suite 7 | Clarkston, WA 99403 | Phone: 509.758.1119 | Fax: 509.758.1140

❑ TriState Wound Healing & Hyperbaric Services ❑ TriState Podiatry (Please check one)

Referral Information

Date ___/___/_____ Referring Provider _____

Referring Phone # _____ Referring Fax # _____

Reason for Referral _____

_____

Patient Information

Patient Name _____ DOB ___/___/_____

Home Phone # _____ Secondary Phone # _____

Mailing Address _____ City _____

State/Zip Code _____ Social Security # _____

Primary Care Provider _____

Please include the following information with this form:

N/A ❑	Included ❑	Demographics, along with current insurance information (legible copy or full front and back information)
N/A ❑	Included ❑	Two most recent office notes
N/A ❑	Included ❑	Diagnostic procedures (x-ray, labs, MRI, CT)
N/A _____	Included ❑	Most recent history and physical (initial if history and physical are not available)

Fax this signed form and other documents to 509.758.1140. If you need to speak with the office staff, please call 509.758.1119. Once the referral information is received, we will call the patient to schedule. We will also notify your office of the appointment date.

Referring Provider's Signature _____