



**REFERRAL FORM
TRISTATE UROLOGY
KENNETH BERGER, MD
DUNCAN HARRIS, MD**

1119 Highland Avenue, Suite 1 | Clarkston, WA 99403 | Phone: 509.254.2722 | Fax: 509.769.2022

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 _____

Specific requests (if applicable) _____

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.