



REFERRAL FORM
TRISTATE UROGYNECOLOGY
JULIUS SZIGETI II, MD
DEZIRAE BERRY, NP-C

1119 Highland Avenue, Suite 4 | Clarkston, WA 99403 | Phone: 509.769.2269 | Fax: 509.769.2270

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 Demographics, along with current insurance information (legible copy or full front and back information)
- N/A Included Diagnostic procedures (x-rays, MRI, CT, labs)
- N/A Included History and physical
- N/A Included Medication list
- N/A Included Two most recent office notes and notes regarding the issue

Fax this form and other documents to 509.769.2270. If you need to speak with the office staff, please call 509.769.2269. Once the referral information is received, we will call the patient to schedule. We will also notify your office of the appointment date.