



REFERRAL FORM
TRISTATE PULMONOLOGY
TELE-HEALTH PULMONOLOGISTS
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)

- COPD _____
- Emphysema _____
- OSA _____
- Lung Nodule _____
- Pulmonary Hypertension _____
- Asthma _____
- Dyspnea _____
- SOB _____
- Sleep Apnea _____
- Cough _____
- Pulmonary Fibrosis _____
- Chronic Pneumonia _____
- Other _____
- Sleep Studies Only (Fax to Sleep Lab at 509.758.4697) _____

Specific requests (if applicable) _____

Please include the following information with this form:

- N/A Included **Last 2 years of labs (CBC, CMP, ABG, Sputum Cultures, ESR, CRP, RF, ANA Titer, Biopsy)**
- N/A Included **Radiology: CT/CTA Chest, Chest X-ray, PET Scan, Cardiac Spect/Stress test**
- N/A Included Medication list
- N/A Included Allergies and intolerances
- N/A Included Last three office notes pertaining to referred problem
- N/A Included Last three chart notes with PCP, cardiology, and oncology
- N/A Included Most recent H&P and discharge summary
- N/A Included Last 5 years of Pulmonology office notes and labs

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 509.769.2219.