TriState Health

REFERRAL FORM
TRISTATE BEHAVIORAL HEALTH
ELINA CHERNYAK, DO
NICK PHILLIPS, MD
JESSICA BRINGMAN, MSN, PMHNP-BC

Date of Referral ___/___/_____ Primary Care Provider _____ Phone # _____

Patient Information

Patient Name _____ DOB ___/___/_____ Age _____

Home Phone # _____ Secondary Phone # _____

Mailing Address _____ City _____

State/Zip Code _____ Social Security # _____

Preferred Pharmacy _____

Insurance Information

Primary Insurance _____

Policy/ID# _____ Group # _____

Secondary Insurance _____

Policy/ID# _____ Group # _____

Work Comp Claim # _____ Carrier _____

Additional Information

Reason for Consult/Working Diagnosis (suspecting) _____

Please give a brief history of symptoms _____

_____

Specific Requests (if applicable) _____

_____

Referring Provider (print name) _____

Referring Provider Phone # _____ Authorization # _____

Please include the following information with this form:

N/A ❑ Included ❑ Last office note specifically related to referral (including past medical and surgical history and current medication/allergies).

N/A ❑ Included ❑ Radiology reports (any imaging related to diagnosis/conditions).

N/A ❑ Included ❑ Labs (any labs completed within the last six months).

N/A ❑ Included ❑ Demographic information with copy of insurance cards.

Please fax this completed form and other documents to TriState Behavioral Health at 509.769.2211.

Contact: TriState Behavioral Health
1271 Highland Avenue, Suite A
Clarkston, WA 99403
Phone: 509.769.2211
Fax: 509.769.2210