TriState Health

REFERRAL FORM
TRISTATE NEPHROLOGY
ONDER ORGUL, MD
STEVE PHAM, DO

1119 Highland Avenue, Suite 5 | Clarkston, WA 99403 | Phone: 509.751.0312 | Fax: 509.751.0314

Referral Information

Date ___/___/_____ Referring Provider _____

Referring Phone # _____ Referring Fax # _____

Reason for Referral _____

_____

Recent Creatinine/bun level _____

Patient Information

Patient Name _____ DOB ___/___/_____

Home Phone # _____ Secondary Phone # _____

Mailing Address _____ City _____

State/Zip Code _____ Social Security # _____

Insurance Information

Primary Insurance _____

Policy/ID # _____ Group # _____

Secondary Insurance _____

Policy/ID # _____ Group # _____

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 (nephrology, oncology, cardiology)

N/A ❑ Included ❑ Most recent history and physical (initial if history and physical are not available)

N/A ❑ Included ❑ Last 2 years worth of labs + renal imaging sent from the PCP (metabolic panel, urinalysis, urine protein- albumin- creatinine, +-most recent CBC and any renal imaging they might have \ had done- including CT abdomen/ pelvis, ultrasound)

Fax this signed form and other documents to 509.751.0314. If you need to speak with the office staff, please call 509.751.0312. 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 _____