



# PATIENT FOLLOW-UP FORM

**INSTRUCTIONS:** Form to be completed by physician/health care provider. Please complete after each appointment with patient. Fax form and accompanying doctor notes to Anchorage Project Access. **Fax to (907) 646-0542.**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

After seeing this Anchorage Project Access patient, next steps include:

<p>I asked the patient to set up another appointment with my office.</p> <p>_____ Next appointment date: _____ Time: _____ AM/PM</p>
<p>The patient needs to be referred to another specialty (must be done through Anchorage Project Access care coordinator).</p> <p>_____ What specialty does the patient require? _____ <input type="checkbox"/> Doctor's notes for referral attached.</p> <p><b>Urgency:      1      2      3      4      5 (circle one)</b></p> <p>Assuming urgency level of:</p> <ul style="list-style-type: none"> <li>▪ 1 is the most urgent (ex: new onset angina) that will need to be checked out in the next 2 weeks.</li> <li>▪ 3 should be something that requires attention but is under control for the short term (ex: chronic illness patient in need of specific guidance).</li> <li>▪ 5 should be an isolated non-urgent medical need (ex: hip replacement).</li> <li>▪</li> </ul>
<p>_____ The patient requires hospital <input type="checkbox"/> inpatient or <input type="checkbox"/> outpatient services (Must be coordinated with Anchorage Project Access care coordinator to make sure all pre-authorizations are obtained prior to services).</p> <p>Procedure Name _____ Covered Diagnosis _____</p> <p>Is general anesthesia required? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Procedure Date _____ Time _____ AM /PM</p> <p>Pre-Op Date _____ Time _____ AM/PM</p> <p>Post-Op Date _____ Time _____ AM/PM</p> <div style="border: 1px solid black; padding: 5px; width: fit-content; margin-left: auto;"> <p>Facility:</p> <p><input type="checkbox"/> Providence</p> <p><input type="checkbox"/> Alaska Regional</p> <p><input type="checkbox"/> Alaska Digestive Center</p> <p><input type="checkbox"/> Alaska Surgery Center</p> <p><input type="checkbox"/> Creekside Surgery Center</p> </div> <p><input type="checkbox"/> APA to schedule History &amp; Physical exam with patient's primary care provider for upcoming surgery?</p> <p><input type="checkbox"/> If so, attach your H&amp;P Exam forms if required.</p> <p><input type="checkbox"/> Doctor's notes for referral attached.</p>
<p>_____ I have resolved the condition for which the patient was referred; no follow up needed.</p>

Other/Notes: \_\_\_\_\_

Provider Information: Signature \_\_\_\_\_ MD / PA / NP Phone \_\_\_\_\_

Printed Name \_\_\_\_\_ Practice Name \_\_\_\_\_

Office Contact Name \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

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