



PATIENT FOLLOW-UP FORM

INSTRUCTIONS: Form to be completed by health care provider after each patient's appointment and faxed to Anchorage Project Access (APA) along with accompanying clinical notes. Please fax to (907) 646-0542.

Patient Name: _____ DOB: _____ Date: _____

After seeing this Anchorage Project Access (APA) 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 APA care coordinator).</p> <p>— What specialty does the patient require? _____ <input type="checkbox"/> Doctor's notes for referral attached.</p> <p>Urgency: 1 2 3 4 5 (circle one)</p> <p>Assuming urgency level of:</p> <ul style="list-style-type: none"> ▪ 1 is the most urgent (ex: new onset angina) that will need to be checked out in the next 2 weeks. ▪ 3 should be something that requires attention but is under control for the short term (ex: chronic illness patient in need of specific guidance). ▪ 5 should be an isolated non-urgent medical need (ex: hip replacement).
<p>— The patient requires hospital <input type="checkbox"/> inpatient or <input type="checkbox"/> outpatient services (Must be coordinated with APA 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 & Physical exam with patient's primary care provider for upcoming surgery?</p> <p><input type="checkbox"/> If so, attach your H&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 Signature _____ MD / PA / NP Phone _____

Printed Name _____ Practice Name _____

Office Contact Name _____ Phone _____ Fax _____

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