REFERRAL FORM

Date: ______________________

INSTRUCTIONS: Form to be completed by health care provider and faxed to Anchorage Project Access (APA) along with accompanying clinical (medical/dental) notes. Please fax to (907) 646-0542.

1. Check **ONE (1)** specialty needed. Use additional forms for multiple specialties.

	Specialty		Specialty
	Allergy/Immunology		Neurology
	Audiology		Occupational Therapy
	Cardiology		Ophthalmology (Cornea/Retina)
	Dental		Pediatric Ophthalmology
	Dermatology		Pediatrics
	Endocrinology		Pediatric/Endocrinology
	ENT		Physical Medicine (EMG Study only)
	Family /Primary Care		Physical Therapy
	Gastroenterology		Podiatry
	Gynecology/Obstetrics		Pulmonary Disease
	Hematology/Oncology		Radiation Oncology
	Infectious Disease		Sleep Disorders
	Medical Oncology		Urology
	Nephrology		Other ______________________

Surgery (check one)

☐ Breast ☐ Cardiothoracic ☐ General

☐ Thoracic ☐ Plastic Reconstruction

☐ Orthopedic (check one)

☐ Hand ☐ Knee ☐ Hip ☐ Shoulder ☐ Spine

Surgical assessment survey: Items must be documented in provider's notes that accompany this referral.

☐ Smoking Cessation ☐ Stable Living Environment
☐ Clinical Depression ☐ Chemical Dependency
☐ Medical Condition ☐ List of medications
☐ Vocation ☐ Height, Weight, Body Mass Index

DIAGNOSTIC SERVICE (Attach Order)

☐ MRI ☐ CT ☐ Ultrasound ☐ PET

☐ Other (describe)

2. Urgency: **1** **2** **3** **4** **5** (please circle one only)

Assuming urgency level of:
1 is the most urgent (e.g. new onset angina) that needs to be evaluated in the next 4 weeks
3 should be something that requires attention but is under control for the short term (e.g. chronic illness patient in need of specific guidance)
5 should be an isolated non-urgent medical need (e.g. hip replacement).

3. Patient referred because: ____

4. Does patient have primary care ☐ Yes or ☐ No. If yes, provider's name ____________________ Phone: __________

5. Patient Name ____________________ DOB __________ Home Phone ____________________

Address: ______________________________________ Cell Phone ____________________

______________________________________ Work Phone ____________________

Alternate Contact ______________________________ Is English second language? Yes or No

Phone # of Contact ______________________________ 1st Language ____________________

6. ***PROGRESS NOTES OR REPORTS FOR SPECIALTY:*** ☐ **Are Attached** ☐ **Will Follow**

RADIOLOGY ORDERS: ☐ **Are Attached** ☐ **Will Follow**

7. Provider Signature ______________________________ MD / PA / NP Phone ______________

Printed Name ____________________ Practice Name ______________________________

Office Contact Name ____________________ Phone ______________ Fax ______________

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