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 (medical/dental) notes. Please fax to (907) 646-0542.

Patient Name: ____ DOB: _______________ Date: ___________________

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

___ I asked the patient to set up another appointment with my office.

Next appointment date: ________________________ Time: ___________ AM PM

___ The patient needs to be referred to another specialty (must be done through APA care coordinator).

What specialty does the patient require? ______________________ ☐ Doctor's notes for referral attached.

Urgency: 1 2 3 4 5 (select one)

Assuming urgency level of:

- **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).

___ The patient requires hospital ☐ inpatient or ☐ outpatient services (Must be coordinated with APA care coordinator to make sure all pre-authorizations are obtained prior to services).

Procedure Name ____ Covered Diagnosis __________________

Is general anesthesia required? ☐ Yes ☐ No

Procedure Date __________________ Time __________AM /PM

Pre-Op Date _____________________ Time ___________AM/PM

Post-Op Date ____________________ Time ___________AM/PM

Facility:

- ☐ Providence
- ☐ Alaska Regional
- ☐ Alaska Digestive Center
- ☐ Alaska Surgery Center
- ☐ Creekside Surgery Center

☐ APA to schedule History & Physical exam with patient's primary care provider for upcoming surgery?

☐ If so, attach your H&P Exam forms if required.

☐ Doctor's notes for referral attached.

___ I have resolved the condition for which the patient was referred; no follow up needed.

Other/Notes: ____

Provider Signature ____MD / PA / NP Phone ______________________

Printed Name _______________________________________ Practice Name ____

Office Contact Name ____________________________________ Phone ___________________ Fax __________________

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