



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.

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 select 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 _____