ANCHORAGE PROJECT ACCESS
CONNECTING TO CARE

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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