REFERRAL FORM

Date: _____

INSTRUCTIONS: Form to be completed by health care provider and faxed to Anchorage Project Access (APA) along with accompanying clinical notes. Please fax to (907) 646-0542 or email to Provider@AnchorageProjectAccess.org

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

☐	Allergy/Immunology	☐	Neurology
☐	Audiology	☐	Occupational Therapy
☐	Cardiology	☐	Ophthalmology (Cornea/Retina only)
☐	Dental	☐	Pediatrics
☐	Dermatology	☐	Phlebology (Vein/Vascular)
☐	Endocrinology	☐	Physical Medicine (EMG Study only)
☐	ENT (Otolaryngology)	☐	Physical Therapy
☐	Gastroenterology	☐	Podiatry
☐	Gynecology/Obstetrics	☐	Pulmonary Disease
☐	Hematology/Oncology	☐	Radiation Oncology
☐	Infectious Disease	☐	Rheumatology
☐	Medical Oncology	☐	Sleep Disorders
☐	Mental Health Services	☐	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 _____ Primary Language _____

Phone # of Contact _____ Interpreter needed? ☐ Yes or ☐ No

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

6.

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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