



# PATIENT ENROLLMENT REFERRAL FORM

Date: \_\_\_\_\_

**INSTRUCTIONS:** Form to be completed by health care provider and faxed to Anchorage Project Access along with accompanying doctor notes. **Fax to (907) 339-8710.**

1. Check specialty or other service needed.

SPECIALTY	
<input type="checkbox"/>	Allergy/Immunology
<input type="checkbox"/>	Anesthesiology
<input type="checkbox"/>	Cardiology
<input type="checkbox"/>	Dermatology
<input type="checkbox"/>	Endocrinology
<input type="checkbox"/>	ENT
<input type="checkbox"/>	Family Medicine/Primary Care
<input type="checkbox"/>	Gastroenterology
<input type="checkbox"/>	Gynecology
<input type="checkbox"/>	Hematology/Oncology
<input type="checkbox"/>	Infectious Disease
<input type="checkbox"/>	Internal Medicine/General
<input type="checkbox"/>	Medical Oncology
<input type="checkbox"/>	Nephrology
<input type="checkbox"/>	Neurology

<input type="checkbox"/>	Obstetrics
<input type="checkbox"/>	Occupational Therapy
<input type="checkbox"/>	Ophthalmology (Cornea/Retina)
<input type="checkbox"/>	Pain Management
<input type="checkbox"/>	Pathology
<input type="checkbox"/>	Pediatric Ophthalmology
<input type="checkbox"/>	Pediatrics
<input type="checkbox"/>	Pediatric/Endocrinology
<input type="checkbox"/>	Physical Medicine/Rehab
<input type="checkbox"/>	Physical Therapy
<input type="checkbox"/>	Podiatry
<input type="checkbox"/>	Pulmonary Disease
<input type="checkbox"/>	Radiation Oncology
<input type="checkbox"/>	Rheumatology
<input type="checkbox"/>	Sleep Disorders
<input type="checkbox"/>	Surgery/Breast

<input type="checkbox"/>	Surgery/Cardiothoracic
<input type="checkbox"/>	Surgery/General
Surgery/Orthopedic (check one)	
<input type="checkbox"/>	Hand
<input type="checkbox"/>	Knee
<input type="checkbox"/>	Hip
<input type="checkbox"/>	Shoulder
<input type="checkbox"/>	Spine
<input type="checkbox"/>	Surgery/Plastic Reconstruction
<input type="checkbox"/>	Surgery/Thoracic-Chest/Lung
<input type="checkbox"/>	Urology
<b>DIAGNOSTIC SERVICE (ATTACH ORDER)</b>	
<input type="checkbox"/>	MRI
<input type="checkbox"/>	Ultrasound
<input type="checkbox"/>	CT
<input type="checkbox"/>	PET
Other (Describe):	

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

Assuming urgency level of:

- 1 is the most urgent (ex: 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 (ex: chronic illness patient in need of specific guidance)
- 5 should be an isolated non-urgent medical need (ex: hip replacement).

3. Patient referred because: \_\_\_\_\_  
\_\_\_\_\_

4. Patient Information:

Name \_\_\_\_\_ DOB \_\_\_\_\_ Home Phone \_\_\_\_\_  
 Address: \_\_\_\_\_ Cell Phone \_\_\_\_\_  
 \_\_\_\_\_ Work Phone \_\_\_\_\_  
 Alternate Contact \_\_\_\_\_ Is English second language? Yes or No  
 Phone # of Contact \_\_\_\_\_ 1<sup>st</sup> Language \_\_\_\_\_

5.

<p><b>PROGRESS NOTES OR REPORTS FOR SPECIALTY:</b></p> <p><input type="checkbox"/> Are Attached      <input type="checkbox"/> Will Follow</p>
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<p><b>RADIOLOGY ORDERS:</b></p> <p><input type="checkbox"/> Are Attached      <input type="checkbox"/> Will Follow</p>
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6. Provider Information:    Provider's Signature \_\_\_\_\_ MD / PA / NP    Phone \_\_\_\_\_

Office Contact Name \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

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