Free Clinic of SW Washington
Project Access Clark County

in partnership with

Project Access NOW
Connecting people to health care. Today.

Date:
To:
Fax:

Patient Follow Up Form

_____ _____ _____
PATIENT NAME PACC ID NUMBER DATE

Next Appointment Date:_____ Time:_____

The patient needs to be referred to another specialty (can only be done by Project Access).

What specialty does the patient require?_____

The patient requires hospital inpatient/outpatient services and/or imaging.
***This requires prior authorization by Project Access. Please complete the information below:**

Procedure: _____ Facility: _____

CPT Code:_____ Diagnosis Code:_____

Please attach all pertinent chart notes in order for the above requests to be processed as quickly as possible.

☐ Patient arrived on time ☐ Patient arrived late ☐ Patient missed appointment

If required, interpretive services were available as scheduled. ☐ Yes ☐ No

☐ Patient thanked the physician/office staff for services received

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

COMMENTS:

_____
_____
_____

signature: _____ **MD/DO/PA/NP**

Project Access Clark County
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Please complete & fax to Project Access Clark County at 360.313.1381