

DRAFT

CARDIOVASCULAR/LIPID CONSULTATION FORM

Patient Please complete section A. Take this form to your physician/specialist when you go for your office visit. Ask him/her to complete Section B. If you use a Cardiovascular Wallet Card or other form to keep track of the dates and results of your heart exams and a list of your current medications, take this information with you and show it to your physician.

Section A. PATIENT INFORMATION

Patient Name: _____ Date of Birth _____

Patient Address: _____

Patient Phone Number: _____

Name of Specialist or Primary Care Provider (PCP): _____

Care Provider Address: _____

Care Provider Phone Number: _____ Care Provider FAX: _____

Section B: RESULTS OF LIPID TESTS

Exam date: ___/___/___

- Lipid values normal _____
- Total Cholesterol elevated _____ Requires Treatment: _____
- LDL level _____ Requires Treatment: _____
- HDL level _____ Requires Treatment: _____
- Triglycerides _____ Requires Treatment: _____
- C-Reactive Protein _____

Follow-up Recommendations:

Care Provider's Name: _____ Signature: _____

Address: _____

Phone Number: _____ FAX Number: _____

Please fax or mail the completed form to the patient's specialist or primary care provider. Thank you.

Extra copies can be downloaded at: <http://www.dhfs.state.wi.us/health/cardiovascular>