

CARDIOVASCULAR / LIPID CONSULTATION RECORD

Patient: Please complete section A for your health care provider when you go for your office visit. Your physician will complete Section B. If you use a Cardiovascular Wallet Card or other means 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 health care provider.

Section A. PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____

Patient Address: _____

Patient Telephone Number: (____) _____

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

PCP Address: _____

PCP Telephone Number: (____) _____ PCP Fax Number: (____) _____

Section B. PHYSICIAN – RESULTS OF LIPID TEST

Test date: _____

Lipid values normal: _____

Total Cholesterol elevated: _____ Requires Treatment _____

LDL Level: _____ Requires Treatment _____

HDL Level: _____ Requires Treatment _____

Triglycerides: _____ Requires Treatment _____

C-Reactive Protein: _____

A1C: _____ Requires Repeat Testing / Treatment _____

Follow-up Recommendations:

Primary Care Provider Name (Print): _____

SIGNATURE – Primary Care Provider: _____

Address: _____

Telephone Number: _____ Fax Number: _____

Fax or mail this completed form to the patient's specialist(s) or Primary Care Provider.

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