

Patient Treatment Summary Communication Form

Receiving Physician _____

Fax Number () _____ - _____ Phone Number () _____ - _____

Sending Physician _____

Fax Number () _____ - _____ Phone Number () _____ - _____

Patient Name _____ Birth Date ___ / ___ / ___ Gender M F

Date of Visit ___ / ___ / ___
(mm/dd/yyyy)

Allergies _____ _____

Reason for Visit

New Patient Evaluation; Chief Complaint _____

Patient Re-evaluation

Past Medical History

Cardiac Event in past 365 days (PTCA, MI, CABG)?

If yes, was LDL ordered?

If yes, was LDL < 100?

If no, was a statin prescribed?

Does patient have a history of HTN?

If yes, is BP < 140/90?

If no, medications started / adjusted

History of Acute MI?

If yes, is patient on a beta-blocker?

If no, specify contraindication(s) _____

Diabetes

Does patient have a history of CHF?

If yes, is patient on an ACEI?

If no, specify contraindication(s) _____

Clinical Assessment and Treatment Plan

Height _____ Weight _____ BMI _____

Blood Pressure _____ Heart Rate _____ EKG _____

Labs Ordered _____

Medications Changed _____

Treatment Plan
