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

_____
_____
_____
_____
_____
_____
_____
_____