



**Cardiology**  
**Continuity and Coordination Report**

\_\_\_\_\_  
Today's Date

**Re:**

**Patient Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

**Date Cholesterol Levels Drawn:** \_\_\_\_\_

**To:**

\_\_\_\_\_  
(Primary Care/Referring Physician)

**Address:** \_\_\_\_\_ **Phone** \_\_\_\_\_

\_\_\_\_\_ **Fax** \_\_\_\_\_

Your patient was examined in this office on the above date. Results of their cholesterol panel are as follows:

- \_\_\_\_\_ Total Cholesterol, *desirable lower than 200*
- \_\_\_\_\_ LDL Cholesterol, *desirable lower than 100*
- \_\_\_\_\_ HDL Cholesterol, *desirable higher than 40*
- \_\_\_\_\_ Triglycerides, *desirable lower than 150*

This information is being sent to you for your review and inclusion in their medical record.

During the visit, your patient was reminded of the clinical practice guidelines for cholesterol screening at least annually (or more frequently as prescribed by a physician).

Recommendations:

- \_\_\_ Repeat cholesterol screening in \_\_\_\_\_
- \_\_\_ Other \_\_\_\_\_

Respectfully submitted,

\_\_\_\_\_  
(Physician Signature)

Print Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

CC: \_\_\_\_\_