Physician to Complete Date of Referral: _____

Patient Name: _____ DOB: _____

Patient's Home Phone Number: _____ Alternate Number: _____

Email:_____

Referring MD: _____ Follow-up (managing) Physician: _____

Office Fax Number to send patient lipid clinic information: _____

→ **PLEASE ATTACH MOST RECENT HISTORY AND PHYSICAL AND LABORATORY DATA IF THAT INFORMATION IS NOT AVAILABLE IN THE CERNER COMPUTER SYSTEM.**

PLEASE COMPLETE THE FOLLOWING INFORMATION

1. Diagnosis: ❒ Pure hypercholesterolemia ❒ Mixed hyperlipidemia ❒ Other and unspecified hyperlipidemia
❒ Essential hypertension; benign ❒ Other _____

2. Requested Lipid Management Service Check all that apply (pharmacist provided care unless otherwise indicated):

❒ Initiate treatment
❒ Assume management
❒ Manage until at goal
❒ Manage indefinitely
❒ Other _____
❒ Nutrition consult (dietician provided)
❒ Consult for intensive lifestyle modification (includes nutrition consult)
❒ Consult for alternative therapy options (includes nutrition consult)

3. Complicating Factors:

❒ Resistant or intolerant to prior therapy
❒ Time to goal is paramount
❒ Complex therapy
❒ Adherence concerns
❒ Renal insufficiency
❒ Suspect genetic dyslipidemia (i.e., TG>500, LDL>190, low HDL, elevated Lp(a))
❒ Metabolic syndrome
❒ Drug interaction concern, adverse drug reaction, polypharmacy
❒ Patient is hesitant to begin therapy
❒ Other: _____

4. History of:

❒ CAD ❒ MI ❒ Stroke ❒ Carotid artery disease ❒ PVD ❒ AAA ❒ DM ❒ CKD or nephrotic syndrome

5. Goal of Therapy: (NCEP ATP III guidelines will be followed if goals are not specified)

LDL goal: _____ HDL goal: _____

6. Activity Restrictions: (Required in order to provide exercise counseling)

❒ No activity restrictions
❒ Yes, the activity restrictions are as follows:_____
❒ Interpreter needed? If so, please indicate language: _____

Physician Signature* **Date** **Time**

Printed Name

*Signature indicates provider's order for evaluation and management of dyslipidemia therapy by Evergreen Hospital Medical Center Pharmacists, assignment of benefits for dyslipidemia management to Evergreen Healthcare and authorization for the use of Washington State Board of Pharmacy approved collaborative management agreement. Ordered Frequency of Laboratory Tests and Evaluation/Monitoring Clinic Visits: Lipid panel+glucose, AST/ALT visit 1 then per treatment plan schedule.

The information on this fax is privileged, confidential, and is intended only for the healthcare practitioner or entity named at the top of this document. If you are not the intended recipient, be notified that you are prohibited from disclosure, copying or distribution of this document or any information contained in it. If you have received this document in error, please immediately notify us by telephone to arrange for the return of the material.

LIPID MANAGEMENT CLINIC (a service within Evergreen's Anticoagulation Clinic)
Phone: (425) 899-3796 Fax: (425) 899-2785 Please fax completed referral forms

EvergreenHealth Kirkland, WA 98034

LIPID MANAGEMENT CLINIC REFERRAL and PHYSICIAN ORDER
FORM ID RX 385
Approved 08/10

APPLY PATIENT LABEL HERE

Original/Fax - Patient Clinic Chart Copy - Medical Records

MR