Center for Coordinated Care
Patient Referral Form
1221 Hayes Avenue Suite B Sandusky, Ohio
Phone: 419-557-6550 Fax: 419-621-1047

Patient Name: ____________________________ **Phone #** (must be provided to contact patient):_____________________

Patient Date of Birth: _______________________

CHOLESTEROL CLINIC PATIENT REFERRAL FORM Phone: 419-557-6550 **Please Complete and Fax this form to the Cholesterol Clinic @ 419.621.1047**	
Patient's Phone #	
REASON FOR PATIENT REFERRRAL:	
	[ ] Hyperlipidemia (includes familial, drug induced, etc)
	[ ] Secondary Prevention after ischemic event
	[ ] Framingham risk score: ________________________________
	[ ] Other:____
	Most recent LIPID Panel Date: _____________ LDL: _______ HDL: __________ Total cholesterol: ___________ TRG: _________
Please send an updated medication list and the patient's last progress note. **Referring physician (Printed Name)** ______________________________________ **Phone Number** ___________________________ **Fax Number** ______________________________	

________________ _________________ __________ _________________________________

Date Time # Provider Signature

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