



CARDIOLOGIST TRANSITIONAL FORM

Patient's name _____
 Phone number _____
 Identification number _____
 Sex: Female Male

Specialist name _____
 Phone number _____
 PCP name _____
 Date of visit _____

Actual History (last 6 months)		Condition Status	Treatment Plan
CODE	Cardiac Disease		
<input type="checkbox"/>	4110 Post MI Syndrome		
<input type="checkbox"/>	4111 Intermed Coronary Syndrome		
<input type="checkbox"/>	4130 Angina Decubitus		
<input type="checkbox"/>	4139 Angina Pectoris Nec/Nos		
<input type="checkbox"/>	4150 Acute Cor Pulmonale		
<input type="checkbox"/>	4160 Prim Pulm Hypertension		
<input type="checkbox"/>	4254 Prim Cardiomyopathy Nec		
<input type="checkbox"/>	4260 Atriovent Block Complete		
<input type="checkbox"/>	4270 Parox Atrial Tachycardia		
<input type="checkbox"/>	4271 Parox Ventric Tachycard		
<input type="checkbox"/>	4272 Parox Tachycardia Nos		
<input type="checkbox"/>	4280 CHF		
<input type="checkbox"/>	4281 Left Heart Failure		
<input type="checkbox"/>	4289 Heart Failure Nos		
<input type="checkbox"/>	40211 Benign Hyp Ht Dis W Hf		
<input type="checkbox"/>	40291 Hypertension Heart Disease nos with HF		
<input type="checkbox"/>	40301 Mal Hyp Kidney Nos		
<input type="checkbox"/>	40391 HTN Kidny Nos W Chr Kid		
<input type="checkbox"/>	40401 Mal Hyp Kid/kidney		
<input type="checkbox"/>	40491 Hyp Hrt/Kid Nos W Hf		
<input type="checkbox"/>	40492 Hyp Hrt/Kid Nos W Chr Kid		
<input type="checkbox"/>	40493 Hyp Hrt/Kid Nos W Hf/Kid		
<input type="checkbox"/>	412 Old Myocardial Infarct		
<input type="checkbox"/>	41090 Acute Miocardial Infarct		
<input type="checkbox"/>	41091 AMI Nos initial		
<input type="checkbox"/>	41181 Acute Cor Occisn W/O Mi		
<input type="checkbox"/>	41189 Ac Ischemic Hrt Dis Nec		
<input type="checkbox"/>	41519 Pulm Embol/Infarct Nec		
<input type="checkbox"/>	42731 Atrial Fibrillation		
<input type="checkbox"/>	42732 Atrial Flutter		
<input type="checkbox"/>	42741 Ventricular Fibrillation		
<input type="checkbox"/>	42742 Ventricular Flutter		
<input type="checkbox"/>	42781 Sinoatrial Dysfunct		
<input type="checkbox"/>	4259 Second Cardiomyopath Nos		
<input type="checkbox"/>	Other Diagnosis		
<input type="checkbox"/>			
<input type="checkbox"/>			

Risk factors	Yes	No
HTN	<input type="checkbox"/>	<input type="checkbox"/>
Obesity	<input type="checkbox"/>	<input type="checkbox"/>
Hypercholesterolemia	<input type="checkbox"/>	<input type="checkbox"/>
Atherosclerosis	<input type="checkbox"/>	<input type="checkbox"/>
Smoker	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>
History of MI	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>

Last admission

Facility name _____

Admission date _____

Admission Dx _____

Discharge date _____

Discharge DX _____

Date of last evaluation of treatment

Last Blood Pleasure

Date	Results
_____	_____

Last lab results (if available)	Date	Results
Total Cholesterol	_____	_____
LDL-C	_____	_____
HDL-C	_____	_____
Triglyceride	_____	_____
C-reactive protein	_____	_____
Fibrinogen	_____	_____
Homocysteine	_____	_____

Special Studies (if applicable/if available)	Date	Results
EKG	_____	_____
Echocardiogram	_____	_____
Holter Studies	_____	_____
Stress Test	_____	_____
Electrophysiologic Studies	_____	_____
Cardiac Cath	_____	_____

I hereby certify that all the information included in this form is fully documented as part of the patient's medical chart and is part of the treatment plan.

Physician signature _____ Date _____ NPI _____