Specialist-PCP Collaborative Care Form

Specialty office will use this form to refer patients with **2** high blood pressure checks (≥140/90) to their PCP. The PCP office will then follow up with the patient.

Date of Care:

To: Primary Care Office:

Practice: Provider name:

Address: Phone ( ) -

Fax ( ) -

City/State/Zip Email:

From: Referring Organization:

Practice: Contact name:

Address: Phone ( ) -

Fax ( ) -

City/State/Zip Email:

Re: Patient Information:

Patient Name (last) (First) DOB:

Address City State:

Zip Code Phone:

Referral Reason:

- **Blood Pressure: "As part of providing comprehensive care, we would like to inform you that upon recheck your patients' blood pressure was _____."**

Referring Clinician Name: **Date:**