# DOT Blood Pressure Follow-up Letter

Employee Name_______________________________________________________

Today your blood pressure in our clinic was __________/__________ and __________/__________.

Please see your Provider as soon as possible for evaluation and treatment of your blood pressure. After blood pressure control is achieved please have your Provider complete the information below and return it to Minnesota Occupational Health.

DOT Examiners Signature_______________________________________________________________ DATE____________________

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## TO BE COMPLETED BY YOUR TREATING PHYSICIAN / MEDICAL PROVIDER

I am the treating physician for this patient. Current blood pressure readings are listed below:

Date:__________/__________/__________ BP: __________/__________

Date:__________/__________/__________ BP: __________/__________

The current medication regimen for treating this driver's hypertension is:_________________________________________________

____________________________________________________________________________________________________________

Treating Provider PRINTED Name _______________________________________________ Date_____________________________

Provider Signature____________________________________________________________ Phone__________________________

Please send to: **Minnesota Occupational Health**

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|---|---|---|---|---|
| ☐ | ST. PAUL LOCATION | 1661 St. Anthony Ave., 2nd Floor, St. Paul, MN 55104 | Ph: (651) 968-5300 | Fax: (651) 646-0205 |
| ☐ | BLAINE LOCATION | 10230 Baltimore Street NE, Blaine, MN 55449 | Ph: (651) 968-5300 | Fax: (651) 730-3516 |
| ☐ | EAGAN LOCATION | 1400 Corporate Center Curve, Suite 200, Eagan, MN 55121 | Ph: (651) 968-5300 | Fax: (651) 730-3523 |
| ☐ | SHAKOPEE LOCATION | 4360 12th Street E, Shakopee, MN 55379 | Ph: (651) 968-5300 | Fax: (651) 730-3551 |