DOT BLOOD PRESSURE FOLLOW-UP LETTER

Employee Name: _____ **Date of Birth:** _____

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 Examiner Signature: _____ **Date:** _____

TO BE COMPLETED BY YOUR TREATING PHYSICIAN / MEDICAL PROVIDER

Date: _____ BP: _____

Date: _____ BP: _____

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

_____

Treating Provider Name: _____ **Date:** _____

Provider Signature: _____ **Phone:** _____

Please have your provider forward the requested information to:

☐ **Coon Rapids Location:** 600 Coon Rapids Boulevard NW, Coon Rapids, MN	**Phone:** (651) 968-5300	**Fax:** (651) 730-3516
☐ **Eagan Location:** 1400 Corporate Center Curve, Suite 200, Eagan, MN	**Phone:** (651) 968-5300	**Fax:** (651) 730-3523
☐ **Shakopee Location:** 4360 12th Avenue E, Shakopee, MN	**Phone:** (651) 968-5300	**Fax:** (651) 730-3551
☐ **St. Paul Location:** 1661 St. Anthony Avenue, 2nd Floor, St. Paul, MN	**Phone:** (651) 968-5300	**Fax:** (651) 646-0205
☐ **Woodbury Location:** 4123 Radio Drive, Woodbury, MN	**Phone:** (651) 968-5300	**Fax:** (651) 730-3574