Queensland Community Pharmacy Chronic Conditions Management Pilot

Cardiovascular Disease (CVD) Risk Reduction Program – Lipid Modification

Clinical Protocol – V2

Eligibility for the Program

Eligibility for participation in the Cardiovascular Disease (CVD) Risk Reduction Program: Lipid Modification (the Program) must be assessed at each consultation, as eligibility may change due to changes in health status or demographic factors. i.e. patients who were previously eligible may become ineligible and patients who were ineligible may become eligible.

Refer the patient to their usual healthcare provider (or emergency services, if required) with a comprehensive clinical handover if the patient is, or becomes, ineligible for management under the Program.

Ineligibility for treatment as part of a Pilot service does not preclude a patient from accessing services provided as part of usual pharmacy care.

Patients who are ineligible for the Program:

Patients who:

- are aged <18 years or >79 years
- are planning a pregnancy or are pregnant
- have an existing diagnosis of:
  - stage 3-5 chronic kidney disease (CKD)
  - familial hypercholesterolaemia
  - type 1 diabetes
  - retinopathy, neuropathy or nephropathy (persistent albuminuria: urinary albumin creatinine ratio (uACR) ≥3 mg/mmol or eGFR <60 mL/min/1.73m^2)
  - complex cardiovascular disease (CVD):

- severe (Grade 3) hypertension (≥180 mmHg systolic and/or ≥110 mmHg diastolic)
- congenital heart disease
- rheumatic heart disease
- heart failure
- arrythmias
- atrial fibrillation
- other conditions including peripheral arterial disease, heart block, pericarditis, valvular disease, pulmonary hypertension, angina, cardiomyopathy and cardiomegaly, aortic aneurysm

- have poorly controlled asthma, moderate or severe chronic obstructive pulmonary disease (COPD), severe obstructive sleep apnoea (OSA) or another serious respiratory illness.
- have a history of:
  - cardiothoracic surgery
  - acute coronary syndrome (e.g., myocardial infarction)
  - stroke or other cerebrovascular disease
  - hypertensive urgency or emergency.
- have a current deep vein thrombosis (diagnosed by a medical practitioner)
- have a current pulmonary embolism (diagnosed by a medical practitioner) or a history of pulmonary embolism
- are currently prescribed anticoagulant therapy
- are currently receiving, or have received within the past 12 months, specialist treatment from a cardiologist, endocrinologist or nephrologist, unless they have a written referral from their treating specialist or general practitioner to participate in the Program
- are suspected to have dyslipidaemia with a secondary cause (e.g. hypothyroidism, cholestasis, nephrotic syndrome)
- have:
  - unexplained fluctuations in blood pressure (BP)
  - total cholesterol ≥7.5 mmol/L, LDL-C ≥5.0 mmol/L or triglycerides ≥6 mmol/L
  - severe hyperglycaemia (glycated haemoglobin (HbA1c) ≥10% or blood glucose level (BGL) ≥20.0 mmol/L), or hypoglycaemia (BGL <4.0 mmol/L)
  - another high risk or abnormal pathology result (e.g., abnormal liver function, abnormal FBC, raised CK) that cannot be managed in the Program.
- are found to have an abnormal lipid profile (but not severely elevated levels), and their CVD risk cannot be determined as they are in a population that the risk calculator is not validated for (e.g., 18 to 29 years old)
- do not reach their lipid levels clinical targets after 6 months of lipid modifying therapy.

Treat (if clinically indicated) and concurrently refer

Provide treatment (if clinically indicated) and concurrently refer the patient to an appropriate healthcare provider for further review if they:

- have type 2 diabetes managed with insulin
- have a history of deep vein thrombosis but are not currently on any antithrombotic therapy.

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When applying the information contained within this clinical protocol, pharmacists should exercise professional discretion and judgement. The protocol supports, but does not replace, the pharmacist's responsibility to make decisions appropriate to the circumstances of the individual, in consultation with the patient and/or their caregiver.

How to use this document

The purpose of the Program is to provide an accessible, community-based healthcare service to identify and improve outcomes for patients at high risk of CVD.

This clinical protocol details how patients in the Program should be managed, including referral to other health services and medical practitioners, pharmacological and non-pharmacological measures, and protocol-based/structured prescribing of medicines for the **management of dyslipidaemia**.

This clinical protocol forms part of the CVD Risk Reduction Program and should be considered in conjunction with the Clinical Protocol: Hypertension and/or the Clinical Protocol: Blood Glucose Management, as required by the patient presentation.

Overview of the CVD Risk Reduction Program: Lipid modification

Assess the CVD risk of patients entering the CVD Risk Reduction Program (see Clinical Protocol: Hypertension for detail on CVD risk assessment).

Reassess CVD risk every 5 years for patients at low CVD risk, or every 2 years for patients at intermediate CVD risk (or sooner where there is a significant change to risk factors) [1].

For patients already receiving pharmacological therapy to reduce their cardiovascular risk, or who have previously been assessed as high-risk, review individual risk factors. Formal reassessment of overall CVD risk is not recommended for these patients [1].

After the patient's CVD risk has been assessed, there are two entry points for patients who are appropriate for enrolment in the Program:

Entry point 1:

- Patients **without a previous diagnosis** of dyslipidaemia, who do not meet any ineligibility criteria, may be enrolled in the Program and **commence management** (with non-pharmacological measures and pharmacotherapy, if indicated) **concurrent to referral** to an appropriate healthcare provider for further review and collaborative care.

Entry point 2:

- Patients **with an existing diagnosis** of dyslipidaemia, who do not meet any ineligibility criteria, may be enrolled in the Program and **commence ongoing monitoring and management** (with non-pharmacological measures and pharmacotherapy, if indicated). **An update must be provided** to the patient's usual healthcare provider following each occasion of care.

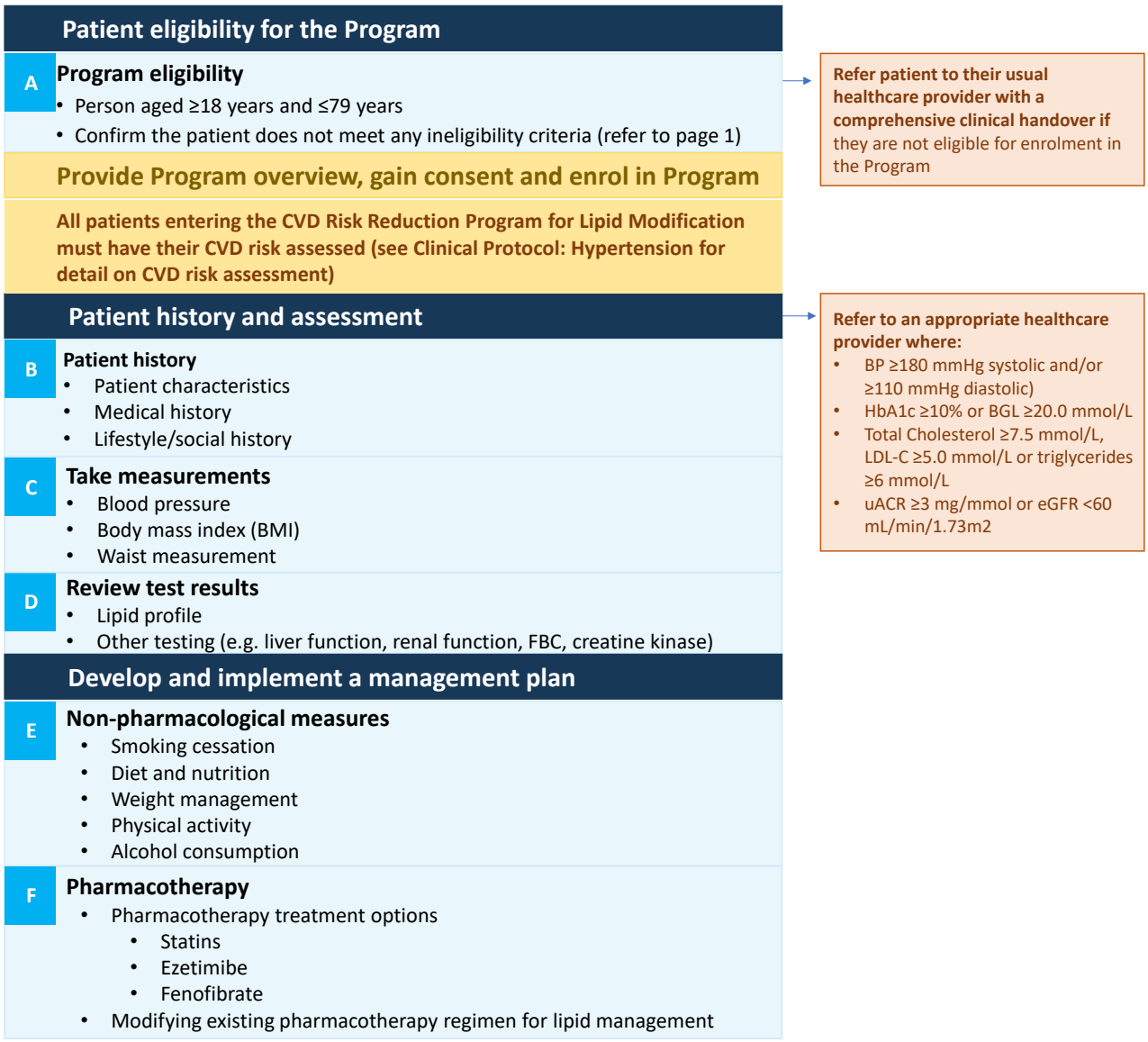
When a patient enters the Program:

- Provide an overview of the Program (see Figure 1), including the aims, expected outcomes, and what the Program may involve (which will vary between patients), including:
  - timeframes for management of the condition, such as the number of appointments and testing required, and the costs involved
  - how the patient's medicines may be managed and how medicine costs may differ when prescribed by a pharmacist

- other interventions that may be recommended as part of the Program e.g., smoking cessation and weight management
- that the patient may leave the Program, including by opting out or becoming ineligible, at any time, and be referred to an appropriate healthcare provider.

- Document informed consent from the patient for participation, as per the Pilot Handbook.

Figure 1: Overview of the CVD Risk Reduction Program: lipid modification



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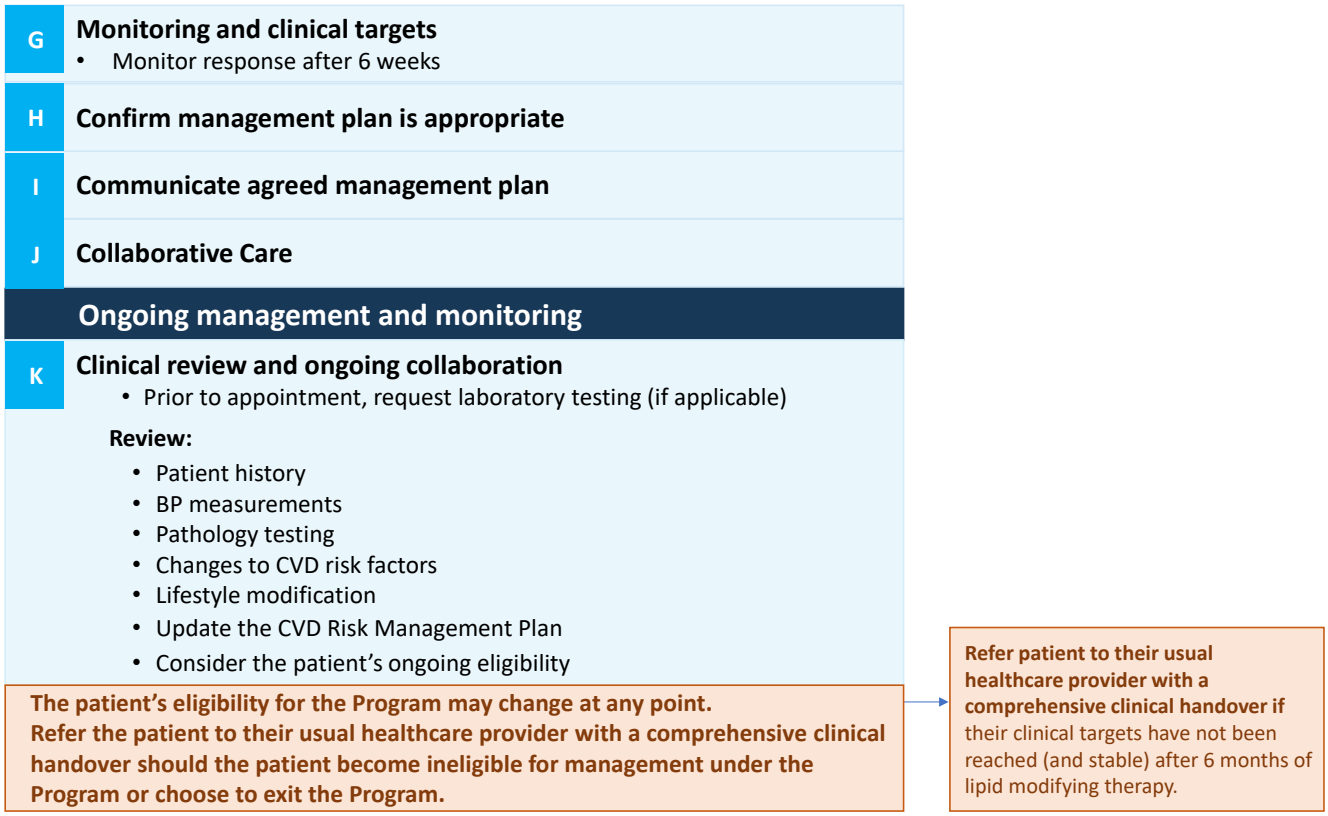

Key points

- CVD is mostly preventable. Most patients who experience a cardiovascular event or develop cardiovascular disease have at least one identifiable CVD risk factor. These risk factors can often be minimised through lifestyle modification and pharmacological interventions [2, 3].
- Decisions regarding the management approach for individual CVD risk factors, including non-pharmacological and pharmacological interventions should be made in the context of the individual's overall CVD risk as well as other comorbidities, personal preferences and psychosocial circumstances [2].
- High cholesterol contributes a third of coronary heart disease burden and is a significant risk factor for CVD [4]. Reduction of plasma concentration of total cholesterol, low-density lipoprotein (LDL) and triglycerides leads to a reduction in CVD risk [1].

Program eligibility

A: Program eligibility

- Confirm eligibility to participate in the Program (see Eligibility).
- Consider program eligibility at every consultation, as eligibility can change at any time.
- Refer the patient to their usual healthcare provider with comprehensive clinical handover if the patient is, or becomes, ineligible for management under the Program.

Patient history and assessment

B: Patient history

Obtain sufficient information to assess the patient's condition, and the safety and appropriateness of any recommendations and medicines for the patient.

Consider:

- age
- ethnic or cultural background, including Aboriginal and/or Torres Strait Islander status
- lactation status
- previous and current medical conditions
- clinical signs of undiagnosed familial hypercholesterolaemia (e.g., tendon xanthomata, corneal arcus before 45 years of age, xanthelasma)
- alarm signs and symptoms that require further investigation (e.g., unexplained weight loss or gain, frequent headache and dizziness, chronic nausea and vomiting)
- family history of CVD, including familial hypercholesterolaemia
- smoking status and history (consider tobacco, cannabis, vaping, passive smoking, or other exposure to smoke)
- all current and recently ceased treatments (including prescribed medicines, vitamins, herbs, other supplements and over-the-counter medicines)
- drug and non-drug allergies. and adverse drug reactions
- recent pathology results, including lipid profile, liver and thyroid function tests
- diet/nutrition status (e.g., fruit and vegetable consumption, volume of processed carbohydrates and saturated fats) and weight
- levels of physical activity
- recreational or illicit drug use, and alcohol use
- specialist involvement in care.

Reminder

Pharmacists can access a range of clinical information in a patient's My Health Record, including details about current and past medication history, allergies and current medical conditions.

C: Take measurements

1) **BP**
   - Conduct BP measurements in accordance with the National Heart Foundation of Australia Guidelines for the diagnosis and management of hypertension in adults 2016 [5].
   - Take three measurements and average the last two. Where there is variation >10 mmHg systolic or >6 mmHg diastolic, have the patient rest quietly for 5 minutes then remeasure.
2) **Weight and height**
   - Take weight and height measurements to calculate the person's body mass index (BMI) (See BMI calculator: Heart Foundation - What's your body mass index (BMI)?) [6]. Refer to

the Department of Health and Aging - BMI and waist measurement [7] for information about BMI ranges and exceptions.

3) **Waist circumference**

   – Measure waist (see Heart Foundation – What waist measurements mean for your heart [8]) and interpret in accordance with the Department of Health and Aging - BMI and waist measurement [7].

D: Review test results

Where recent test results are unavailable, undertake appropriate testing (point of care testing (PoCT) and/or laboratory testing). Refer to the Pilot Handbook for further information regarding options for requesting laboratory testing.

Lipid profile

- Patients with abnormal lipid levels identified during CVD risk assessment should have a repeat fasting lipid profile conducted on another day to confirm the result and inform management [9].

Other testing

- Consider if any other PoCT or laboratory testing (e.g., liver function, renal function, full blood count, creatine kinase) is needed to inform patient management. See G: Monitoring and clinical targets for more information.

Develop and implement a management plan

High cholesterol accounts for one-third of the coronary heart disease burden and is a significant risk factor for CVD [2]. A holistic approach to managing overall CVD risk is more effective than managing individual clinical risk factors (i.e., hypertension, dyslipidaemia and hyperglycaemia) in isolation [1,2].

Each patient should have a CVD Risk Management Plan developed (see Appendix 1), which outlines lipid modification targets and addresses each modifiable risk factor in accordance with the *Therapeutic Guidelines* and other relevant Australian guidelines.

The CVD Risk Management Plan may include:

- appropriate clinical targets
- lifestyle modification and non-pharmacological measures
- pharmacotherapy
- plan for review.

Patients should be involved in shared decision-making and the development of their CVD Risk Management Plan, including setting of appropriate targets.

E: Non-pharmacological measures

Provide all patients with information about non-pharmacological measures, regardless of whether pharmacotherapy is prescribed.

The 5As Framework for behavioural risk modification may be used as the basis for identifying modifiable lifestyle risk factors and implementing lifestyle interventions in accordance with the Royal Australian College of General Practitioners - Smoking, nutrition, alcohol and physical activity (SNAP) guide [10].

Lifestyle modification (e.g. dietary changes, physical activity) can improve lipid concentrations [2].

Smoking and vaping cessation

Detailed guidance for pharmacists supporting smoking cessation is contained in the Smoking Cessation - Clinical Practice Guideline [11] and supporting vaping cessation is contained in the E-cigarette and Vaping Cessation Guide [12].

Weight management

Lipid concentrations are shown to improve with weight loss in patients who are overweight or obese [2].

Detailed guidance for pharmacists supporting weight management in contained in the Management for Overweight and Obesity – Clinical Practice Guideline [11].

Diet and nutrition

Nutritional management should focus on a balanced diet, with foods from each of the five food groups in appropriate portions to maintain a healthy weight. Foods that are high in saturated and trans fats, sugar and sodium (e.g., highly processed foods) should be limited [9, 13, 14]. Nutritional recommendations and advice should be sourced from the Australian Dietary Guidelines [14].

Patients with dyslipidaemia should [2, 15]:

- reduce saturated and trans-fat intake by replacing them with mono and poly-unsaturated fats (avocado, nuts, seeds and vegetable oils)
- increase fibre intake (particularly soluble fibre e.g., oats, psyllium and legumes)
- use products enriched with plant sterols
- include soy protein in their diet through soy milk and/or soy cheese
- aim for 2-3 servings of oily fish per week (salmon, mackerel and tuna).

Encourage all patients with an intermediate or high CVD risk to see a dietitian for individualised nutritional advice.

Physical activity

Encourage all patients to undertake regular physical activity in line with recommendations for their age group in the Physical activity and exercise guidelines for all Australians [16].

Consider the patient's ability to safely exercise, including current mobility and flexibility. Referral to an exercise physiologist and/or physiotherapist to develop an exercise plan may be required.

Alcohol consumption

Alcohol consumption has a mixed effect on lipid profile. Recommendations and advice regarding alcohol consumption should be sourced from the Australian guidelines to reduce health risk from drinking alcohol [17].

Pharmacist resources

- Royal Australian College of General Practitioners - The Handbook of Non-Drug Interventions (HANDI) [18]
- Royal Australian College of General Practitioners - Guidelines for preventive activities in general practice [9]

F: Pharmacotherapy

Pharmacotherapy for the Program involves the following components, where appropriate:

- initial management of dyslipidaemia
- maintenance management of dyslipidaemia (including adjusting pharmacotherapy as needed).

See Overview of the CVD Risk Reduction Program: Lipid modification for entry points to the Program.

Where pharmacotherapy is prescribed, the patient's prescription(s) (including repeats) should provide enough medicine for the period until the patient's next scheduled review.

Lipid modifying pharmacotherapy must be in accordance with the current online versions of Therapeutic Guidelines: Cardiovascular (Lipid modification) [2], and the Australian Medicines Handbook - Drugs for dyslipidaemia) [19].

To determine whether pharmacotherapy for lipid modification should be initiated (or modified), consider the patient's:

- age
- liver function
- CVD risk
- current lipid profile
- related comorbidities
- clinical targets relevant to the individual
- contraindications, adverse reactions and drug interactions
- response to previous interventions to reduce lipids (non-pharmacological and pharmacological)
- patient preference (including cost).

For pharmacotherapy approach, see Table 1.

Table 1. Approach to lipid modification [1, 2]

Category	Recommendation
High CVD risk	• Pharmacotherapy is recommended for all patients in addition to lifestyle modification
Intermediate CVD risk	• Consider lipid modifying pharmacotherapy depending on the clinical context • A trial of lifestyle modification may be sufficient to manage CVD risk • Discuss the potential benefits and harms of treatment with the patient and encourage shared decision-making.
Low CVD risk	• Pharmacotherapy is not routinely recommended • If dyslipidaemia is present, discuss lifestyle modification. Lipid-modifying pharmacotherapy can be considered in those who do not reach the LDL-C target with lifestyle support
Severe hyperlipidaemia (serum total cholesterol ≥7.5 mmol/L or LDL cholesterol ≥5 mmol/L)	• Manage regardless of AusCVDRisk calculator results. • Refer these patients to their usual healthcare provider for management.

Table 1. Approach to lipid modification [1, 2]	
Abnormal lipid levels (but not severe hyperlipidaemia) in patients who cannot have their CVD risk calculated	• Patients that belong to a population for which the Australian CVD risk calculator has not been validated, e.g. type 1 diabetes. • Refer these patients to their usual healthcare provider for review and possible management.

Pharmacotherapy treatment options under the Program

Pharmacists may prescribe up to two agents (dual-therapy) from the following list in line with the current online version of Therapeutic Guidelines: Cardiovascular (Lipid modification) [2]:

- statins (first line therapy unless contraindicated or not tolerated). Initiate high dose of a high potency statin if the patient has a high CVD risk or LDL-C levels are >4.0 mmol/L
- ezetimibe (may be used as monotherapy if statins are contraindicated or not tolerated)
- fenofibrate (may be used as additional therapy to meet triglyceride targets).

Combination products can be prescribed if appropriate, however they must only include medicines able to be prescribed under the Program.

The pathology testing that is required before pharmacotherapy is initiated or modified, and during treatment is summarised in Table 2.

Patients entering the program with an existing medicine regimen for lipid modification

Consider whether the most recently prescribed treatment is:

- appropriate for the patient's symptoms and medical history
- optimised for the patient, including the therapeutic response and progression towards clinical targets
- tolerable, with minimal, or appropriate management of, adverse effects.

Pharmacists may modify or adjust existing lipid modification pharmacotherapy, including if the:

- patient's response is inadequate (within appropriate clinical timeframes)
- patient is experiencing intolerable or unmanageable adverse effects.

When considering modification or adjustment to medicines prescribed, consider if the medicine is **also** used for the treatment of another condition.

When modifying pharmacotherapy regimens for lipid modification that have been prescribed by another healthcare provider, attempt to notify and make changes in collaboration with the original prescriber or the patient's usual healthcare provider (whichever is most appropriate).

G: Monitoring and clinical targets

Monitor response to new or changed pharmacotherapy by measuring lipid concentrations **after 6 weeks** (see Table 3 for target levels) [2].

If already prescribed a statin but not reaching clinical targets [2]:

- review adherence and address any issues
- consider increasing the dose of the statin (if not already at maximum dose) or switching to a high potency statin
- consider adding a second medicine and modify the dose to optimise management:

- ezetimibe (if LDL-C targets are not being met)
- fenofibrate (if triglyceride targets are not being met on a combination of statin and fish oil).

If clinical targets have not been reached 6 months after commencing lipid modifying therapy, refer the patient to an appropriate healthcare provider for ongoing management. If clinical targets have been reached after 6 months in the Program, continue to monitor response to therapy.

Table 2. Tests and monitoring required for lipid modifying therapies [1, 2]

Drug class	Test
Statins (HMG CoA Reductase Inhibitors)	• Blood tests for baseline liver function and creatine kinase (CK) should be taken before initiating and re-tested if clinically indicated.
Fenofibrate	• Blood tests for full blood count and liver function should be taken before initiating and at 3 monthly intervals during the first year of treatment. • Serum CK should be taken before initiating and repeated regularly if using in combination with a statin. • Monitor renal function and reduce dose if CrCl is 30–60 mL/minute. • HDL - paradoxical decrease in HDL concentration has occurred weeks to years after starting fenofibrate; consider stopping fenofibrate if HDL is markedly decreased from baseline.

Table 3. Target levels of cholesterol [2, 9]

Cholesterol type	Target level
LDL-C	• High CVD risk: at least 50% reduction from baseline and <1.8 mmol/L, whichever is lowest • Intermediate CVD risk: <2.6 mmol/L • Low CVD risk: <3 mmol/L
Non–HDL-C	• High CVD risk: <2.6 mmol/L • Intermediate CVD risk: <3.4 mmol/L • Low CVD risk: <3.8 mmol/L
Triglycerides	• High CVD risk: <1.7 mmol/L • Intermediate and low CVD risk: <2.0 mmol/L

H: Confirm management plan is appropriate

Consult the *Therapeutic Guidelines* [2], the *Australian Medicines Handbook* [19] and other relevant resources to confirm that management is appropriate, including:

- contraindications and precautions
- drug and disease interactions
- lactation status.

I: Communicate agreed management plan

Provide comprehensive advice (including supporting written information) to the patient regarding:

- individual product and medicine use
- non-pharmacological measures
- how to manage adverse effects
- when to seek further care and/or treatment
- when to return for clinical review.

Document the agreed management plan and individualised clinical targets within the patient's CVD Risk Management Plan.

It is the pharmacist's responsibility to ensure the suitability and accuracy of any resources provided to patients (and caregivers if applicable) and that they comply with all copyright conditions.

J: Collaborative care

Provide a copy of the patient's CVD Risk Management Plan to the patient's usual healthcare provider (and any other relevant health professionals involved in the patient's care). The communication should also include (if relevant):

- relevant medical history and pathology/PoCT results
- changes to existing pharmacotherapy or new pharmacotherapy prescribed
- a summary of advice provided to the patient including recommendations for multidisciplinary care and referrals
- the next scheduled review appointment.

Ongoing management and monitoring

K: Clinical review and ongoing collaboration

All patients should undergo regular clinical review to participate in the Program. Review patients **6 weeks** after initiating or modifying the treatment regimen or sooner, if required or as recommended [2].

Prior to each periodic review, arrange any relevant laboratory tests (that are not performed by PoCT) required for monitoring.

At each appointment (scheduled or unscheduled), review:

- the patient's ongoing eligibility for the Program
- patient history to reflect changes in the preceding period
- BP measurements
- pathology or undertake any required PoCT (as applicable)
- changes to CVD risk factors
- patient's response to current management and adherence to lifestyle modification
- prescribed pharmacotherapy and modify the treatment regimen in line with Therapeutic Guidelines or consider other medicine-related issues (e.g., adherence)
- CVD Risk Management Plan, document and update clinical targets, if required.

Provide an update to the patient's usual healthcare provider following each occasion of care including when any changes are made to the patient's management plan. Proactive, planned and/or unplanned review may also occur with the patient's usual healthcare provider at any time while the patient is enrolled in the Program.

Patients may continue to participate in the Program providing:

- their condition remains eligible to be managed in the Program
- they wish to remain in the Program and continue to consent
- they attend scheduled reviews.

Patients are not eligible for participation in the Program if their clinical targets have not been reached after 6 months of lipid modifying therapy.

Refer all patients (with their consent) who are no longer eligible for management within the Program, or who do not wish to continue in the Program, to an appropriate healthcare provider.

Appendices

Appendix 1 – CVD Risk Management Plan

For an editable version, see CVD Risk Management Plan - editable.

Page 1

Queensland Community Pharmacy Chronic Conditions Management Pilot

Cardiovascular Disease (CVD) Risk Management Plan

Plan date:

Name:		Date of birth:	
Date of enrolment in the CVD Risk Reduction Program:			
Patient support person and/or caregiver:			

Program pharmacy details

Pharmacist name		Phone number	
Pharmacy name and address		Opening hours	

My CVD Risk

Estimated CVD risk (AusCVDRisk):	Low (%), Intermediate (%), High (%)
My CVD risk factors	Insert applicable risk factors e.g., • high blood pressure • type 2 diabetes (hyperglycaemia) • above healthy weight range • smoking • waist circumference • dyslipidaemia, specifically high levels of 'bad' cholesterol and/or low levels of 'good' cholesterol • family history of premature CVD etc.
My risk of type 2 diabetes	Low (score), Moderate (score), High (score) (delete if already diagnosed with T2DM)

My clinical targets and test results

Blood lipids (cholesterol)			
Current blood lipid levels		Blood lipid targets (individualise as required)	
Total cholesterol	mmol/L	Total cholesterol:	Less than 5.5/ 4.0 mmol/L
LDL-C	mmol/L	LDL-C:	Less than 2.0 mmol/L
HDL-C	mmol/L	HDL-C:	Higher than 1.0 mmol/L
Triglycerides	mmol/L	Triglycerides:	Less than 2.0 mmol/L

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My lifestyle prescription

Physical activity	• Enter recommendations for physical activity for the patient's age and capability based on the national guidelines:
	  ○ Informal activity e.g. everyday activities i.e. housework, gardening
	  ○ Formal activity e.g., walking (moderate intensity) for 30 minutes 5 days of the week, strength building 2 days per week
	  ○ Individualised guidance based on patient preference and affordability
	  ○ Incorporate pacing by building up to recommendations
	• If required: Refer to a GP, exercise physiologist, physiotherapist or other supports for safe exercise

Weight management and diet and nutrition	• Recommendation for weight loss (if applicable)
	• Recommendations for eating for health
	• Summary of nutritional advice for a balanced diet
	  ○ more of/ increase…
	  ○ less of/ limit…
	• Specific advice and food recommendations tailored for individual's risk factors
	• If required: Refer to Management for Overweight and Obesity - Clinical Practice Guideline and/or other supports e.g.,dietitian

Other lifestyle modification strategies	• If required: Smoking (or vaping) cessation ○ Refer to Smoking Cessation - Clinical Practice Guideline, E-cigarette and Vaping Cessation Guideline and/or other supports e.g. Quitline or GP • If required: Refer to a GP, psychologist or other mental health clinician for mental health support • If required: Summary of advice regarding alcohol consumption • If required: Sleep hygiene education

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My medicines for reducing cardiovascular disease risk

- include medicines prescribed by another health practitioner (if applicable)
- delete rows/sections not required

Blood lipids (cholesterol)	
Medicine name	Instructions
	• dose, formulation, frequency, time of day, duration • other instructions e.g., take with food • serious adverse effects that require immediate medical review
Other medicines for CVD Risk Reduction	
Medicine name	Instructions

Advise your pharmacists if you are experiencing side effects from medication or if you have any concerns.

Your next review appointment with your pharmacist in the Program is:	
You need to get the following tests done (using the pathology request provided) before your next appointment:	

Healthcare team

General practitioner and clinic:	Name, address and phone number	Closest 24-hour emergency services:	Name, address and phone number
Dietitian	Name, address and phone number	Exercise physiologist	Name, address and phone number
Other health practitioner	e.g. diabetes educator Name, address and phone number	Other health practitioner	Name, address and phone number

Document version number	Date	Comments
Version 1.0	01.02.2024	
Version 1.1	11.11.2024	Administrative update.
Version 1.2	01.07.2025	Administrative updates across sections to improve useability of the CVD protocols.
Version 2.0	07.04.2026	Updates across sections to reflect contemporary guidance and improve usability.

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