BLOOD PRESSURE SCREENING

Date of Screening: _____ **Location:** _____

Client Name: _____

Contact Information: _____

YOUR BLOOD PRESSURE TODAY IS _____/_____.

BP type	Follow-Up Recommendations	Lifestyle Recommendations
☐ **Normal** ☐ **Pre-Hypertension** ☐ **Stage 1 Hypertension** ☐ **Stage 2 Hypertension**	☐ **Recheck BP each year.** ☐ **If on meds, recheck per medical professional or doctor directions.** ☐ **If no meds, recheck BP in 1 month or earlier.** ☐ **Recheck BP within one day.** ☐ **See your medical professional or doctor within 1 week.** ☐ **See your medical professional or doctor within _____ days.** ☐ **Contact doctor or ER *without delay* for evaluation.** ☐ **Other** _____ _____	☐ **Regular exercise** ✓ 3 times weekly for 30 minutes ☐ **Well-balanced diet** ✓ 5 servings of fruits and vegetables daily & low-fat dairy products ☐ **Limit sodium** ✓ About 2 grams salt per day *(1 teaspoon = 2.4 grams)* ☐ **Healthy body weight** ✓ Maintain **B**ody **M**ass **I**ndex of 18.5 – 24.9 BMI = *(weight in lbs. x 703) ÷ (height in inches) ÷ (height in inches)* ☐ **Limit alcohol** ✓ 1 drink is one 12 oz. of beer or 4 oz. of wine ☐ **Eliminate smoking** ✓ Contact your medical professional or doctor for additional support ☐ **Other** _____
Comments:		
FCN name:		

Participation in this screening is voluntary and may include a referral to physician and follow-up with nurse. All information obtained on this form will be kept confidential. Participation in this program cannot substitute for consultation with a physician or other medical professional for any medical or health-related condition.

BLOOD PRESSURE MONITORING

Name:		Standing		Sitting		Comments
Date:	Location:	Blood Pressure	Pulse	Blood Pressure	Pulse	
		/		/		
		/		/		
		/		/		
		/		/		
		/		/		

Name:		Standing		Sitting		Comments
Date:	Location:	Blood Pressure	Pulse	Blood Pressure	Pulse	
		/		/		
		/		/		
		/		/		
		/		/		
		/		/		

Name:		Standing		Sitting		Comments
Date:	Location:	Blood Pressure	Pulse	Blood Pressure	Pulse	
		/		/		
		/		/		
		/		/		
		/		/		
		/		/		

Name:		Standing		Sitting		Comments
Date:	Location	Blood Pressure	Pulse	Blood Pressure	Pulse	
		/		/		
		/		/		
		/		/		
		/		/		
		/		/		

MEDICATIONS SHEET

Client Name: _____

Pharmacy: _____ **Phone:** _____

Physician Name: _____ **Physician Phone:** _____

Known Allergies: _____

Name (Generic/Brand/ OTC)	Dose	Frequency	Prescribed By	Purpose of Medication	Date and Initials

_____ _____ _____

Faith Community Nurse Signature **FCN Initials** **Date**

NARRATIVE NOTES

Client Name: _____ **Date of Notes:** _____

Faith Community Nurse: _____ **Faith Community:** _____

Location of Contact (Circle): Faith Community Home | Agency/Office Nursing Home | Hospital | Phone

Notes: