Hypertension Referral Form

Patient Name: _____ DOB:_____

Provider Recommending Referral: _____ Date:_____

First BP Reading: _____ Repeat BP Reading: _____

REASON FOR REFERRAL	SERVICES REQUESTED
☐ Elevated BP at today's appointment. (140+/90+) ☐ Previously diagnosed hypertension – elevated today. ☐ Secondary hypertension due to: _____ ☐ Other: _____	☐ Ambulatory blood pressure monitoring and report only *(nurse visit)*. ☐ Medical Provider Consultation / Appointment ☐ Other:

To be completed by medical personnel:

Date: _____

Nurse: _____ Provider: _____

BP Reading: _____/_____

Actions/Recommendations: