blood pressure flow sheet

Name:	DOB:	M/F	Ethnicity:
Allergies:	Advance Directive Discussion Date: Copy of Advance Directive in Chart: Y/N		

Pharmacy: ______________________________ Phone: ____________

Hypertension Diagnosis: ______________ Date HTN Dx.: ______________

Diabetes Diagnosis: ______________ Date of DM Dx: ______________

Treating Provider Name: ______________________________

Date (mm/dd/yyyy)	Blood Pressure Recording	Actions (Recheck BP if >140/90 mmHg)
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***HEDIS® Requirement** – HEDIS® is a registered trademark of the National Committee for Quality Assurance. Quality reviews are performed annually on randomly selected patients. Keeping this form updated will reduce the need for excess medical record copying during the HEDIS Medical Record Review.