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.