Parish Nurse Blood Pressure Screening Record

Signature ______________________________ **Date** _______________

Name	B/P	Comments
		☐ Referred to Physician ☐ Recommended repeat B/P check in ________ ☐ Encouraged Lifestyle Modification ☐ Other ↓ Alcohol ↓ Salt Intake Wt. Loss ↑ Exercise
		☐ Referred to Physician ☐ Recommended repeat B/P check in ________ ☐ Encouraged Lifestyle Modification ☐ Other ↓ Alcohol ↓ Salt Intake Wt. Loss ↑ Exercise
		☐ Referred to Physician ☐ Recommended repeat B/P check in ________ ☐ Encouraged Lifestyle Modification ☐ Other ↓ Alcohol ↓ Salt Intake Wt. Loss ↑ Exercise
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