Quality Improvement Organizations
Sharing Knowledge. Improving Health Care.
CENTERS FOR MEDICARE & MEDICAID SERVICES

Healthcentric Advisors

Patient Onboarding Registration Form

Self-Measured Blood Pressure Monitoring to Improve Uncontrolled Hypertension

Patient Information

Patient Name: ____ **Date:** ____/____/______

Address: ______________________________________ **City:** _____________ **Zip Code:** ________ **State:** _____

Phone Number: (__ __ __) __ __ __ - __ __ __ __ **Alternative Phone Number:** (__ __ __) __ __ __ - __ __ __ __

Cell phone is a smartphone? ❑ Yes ❑ No ❑ Unsure

Make & Model (Ex: Apple, iPhone 10): ___________________________________

Is less than 3 years old: ❑ Yes ❑ No ❑ Unsure **Touch-screen?** ❑ Yes ❑ No ❑ Unsure

Has a data plan or access to Wi-Fi: ❑ Yes ❑ No ❑ Unsure **Bluetooth-enabled:** ❑ Yes ❑ No ❑ Unsure

Uses: ❑ Android OS (6.0+) ❑ Apple iOS (10.0+) ❑ Unsure

Email Address: ____

Emergency Contact: _________________________________ **Relationship:** _________________________

Emergency Contact Phone: (__ __ __) __ __ __ - __ __ __ __

Physician Information

Physician: ____________________________________ **Practice Name:** ____________________________

Practice Address: _________________________________ **City:** _____________ **Zip Code:** ________ **State:** ___

Physician Email for Alerts: ____

Practice Phone: (__ __ __) __ __ __ - __ __ __ __ **Practice Fax:** (__ __ __) __ __ __ - __ __ __ __

Point of Contact for Alerts: _____________________________________ **Title:** ____________________

Phone: (__ __ __) __ __ __ - __ __ __ __ **Email:** ____

This material was prepared by Healthcentric Advisors, the Medicare Quality Innovation Network-Quality Improvement Organization for New England, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. CMS-SIP_BP-20190910-10 *Last Rev: 09/18/19*

To be completed from referral form

Medical Record Number: ____

Blood Pressure: ____ /____ **mmHg** **Pulse:** ____ **bpm** **Date:** ____ /____ /______ **Arm:** ❑ Left ❑ Right

Blood Pressure: ____ /____ **mmHg** **Pulse:** ____ **bpm** **Date:** ____ /____ /______ **Arm:** ❑ Left ❑ Right

Source of Readings: ❑ Doctors Office ❑ Omron Blood Pressure Cuff

Contraindications for using Right or Left arm for Blood Pressure Reading? ❑ Yes ❑ No

If yes, which arm? ❑ Left ❑ Right

Upper Arm Circumference: __________ inches **Which arm?** ❑ Left ❑ Right

Omron Cuff Style: ❑ Upper Arm ❑ Wrist **Serial Number:** ____________________ ❑ User 1 ❑ User 2

If 2 people are sharing a unit, who is the other person? ____

Alert Settings

Default High Systolic:	160	**Default High Diastolic:**	100
Default Low Systolic:	100	**Default Low Diastolic:**	60
Critical Systolic:	180	**Critical Diastolic:**	110
High Systolic:	__________	**High Diastolic:**	__________
Low Systolic:	__________	**Low Diastolic:**	__________

Frequency of readings after the first week of 2xd x 7d: ❑ 5x week + prn ❑ 3x week + prn

Medication

Blood Pressure Medication: _________________________________ **Dose:** __________ **Frequency:** ____________

Blood Pressure Medication: _________________________________ **Dose:** __________ **Frequency:** ____________

Blood Pressure Medication: _________________________________ **Dose:** __________ **Frequency:** ____________

Blood Pressure Medication: _________________________________ **Dose:** __________ **Frequency:** ____________

Notes: ____

For Healthcentric Advisors ONLY

SMBP Education Completed: ❑ Yes ❑ No **Date:** ___ /___ /______ **Staff Member:** _______________

SMBP Return Demo: ❑ Yes ❑ No **Date:** ___ /___ /______ **Staff Member:** _______________

Omron Cuff Style: ❑ Upper Arm ❑ Wrist **Serial Number:** _______________________________

Omron Assigned Number: ________________________ **HCA Assigned Number:** _____________________

Mini Course Completed: (1) ❑ Yes ❑ No **Date:** ___ /___ /______ **Staff Member:** _______________

Mini Course Completed: (2) ❑ Yes ❑ No **Date:** ___ /___ /______ **Staff Member:** _______________