Quality Improvement Organizations
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CENTERS FOR MEDICARE & MEDICAID SERVICES

Healthcentric Advisors

Referral Form

Self-Measured Blood Pressure Monitoring to Improve Uncontrolled Hypertension

Please provide the most recent information below for the patient indicated. If the information is unknown, please leave blank. Patients referred to this pilot must have a diagnosis of uncontrolled HTN (> 140/90). Please refer to the table below. Patients referred will be screened to see if they are eligible and agree to participate. A 'Close the Loop' form will be sent back to the practice to inform you if the patient was on-boarded into the pilot, didn't qualify, was unable to be reached or refused participation.

BLOOD PRESSURE CATEGORY	SYSTOLIC mm Hg (upper number)		DIASTOLIC mm Hg (lower number)
NORMAL	LESS THAN 120	and	LESS THAN 80
ELEVATED	120 – 129	and	LESS THAN 80
HIGH BLOOD PRESSURE (HYPERTENSION) STAGE 1	130 – 139	or	80 – 89
HIGH BLOOD PRESSURE (HYPERTENSION) STAGE 2	140 OR HIGHER	or	90 OR HIGHER
HYPERTENSIVE CRISIS (consult your doctor immediately)	HIGHER THAN 180	and/or	HIGHER THAN 120

Date of Referral: ___ / ___ / _____ **Date of Uncontrolled HTN Diagnosis:** ___ / ___ / _____

Name of Referring Provider: _____ **Phone Number:** (_ _ _) _ _ _ - _ _ _ _

Patient Name: _____ **Patient Cell Phone #:** (_ _ _) _ _ _ - _ _ _ _

Alternative Phone #: (_ _ _) _ _ _ - _ _ _ _

May we leave a message with the phone number(s)? ☐ Yes ☐ No

Patient Date of Birth: ___ / ___ / _____ **Medical Record Number:** _____

Type of Insurance: *(Select all that apply)*
☐ Medicare ☐ Medicare Advantage ☐ Medicare Other: _____
☐ Medicaid ☐ Private ☐ Other: _____

Language Preference: ☐ English ☐ Spanish ☐ Other: _____

Are there contraindications to having a BP reading in either arm? (e.g., s/p mastectomy, shunt) ☐ Yes ☐ No

If yes, which arm? ☐ Left ☐ Right

Medication for HTN:	Dose:	Frequency:	Notes:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Blood Pressure Levels Chart from American Heart Association (heart.org/bplevels)

There are standardized default settings for the high and low BP reading alerts as seen in the table below. Additionally, there is a requirement for the patient to take their BP reading 2 x d/ 7days for the first week to establish the baseline. Thereafter the default frequency decreases and prn added if symptoms occur. Providers may customize the default settings on the alerts and after the first week can customize the frequency of the readings, with 3x/wk being the minimum. **Please note you can customize the settings at any point during the pilot.**

Default Alerts			**Preferred Customized Alert (Please complete ONLY if the default setting is not appropriate for this patient)**	
	Systolic	**Diastolic**	**Preferred Systolic**	**Preferred Diastolic**
High	160	100		
Low	100	60		
Critical	180	110		

Timeframe	**Default BP Reading Frequency**	**Preferred Customized Frequency* (Please complete ONLY if the default frequency is not appropriate for this patient) *Can NOT be less than 3x/wk**
Week 1	2x/day x 7days	
Week 2	5x/ week & prn	
Week 3 forward	3x/ week & prn	

Please complete & include the last 2 BP readings if available

Blood Pressure:	**_____/_____ mmHg**	**Pulse:**	**_____**	**Date:**	**___ / ___ / _____**	**Arm_____**
Blood Pressure:	**_____/_____ mmHg**	**Pulse:**	**_____**	**Date:**	**___ / ___ / _____**	**Arm_____**

Height:	**_____'_____" Ft/in**	**Date:**	**___ / ___ / _____**
Weight:	**_____ Lbs.**	**Date:**	**___ / ___ / _____**
BMI:	**_____**	**Date:**	**___ / ___ / _____**

Please fax this completed form via secure fax: 401 - 528 - 3237 • Attention: Alyson Schena	**Questions? Contact Alyson Schena at 401 - 528 - 3247**
Healthcentric Advisors Use Only:	**Date Contacted Patient: ___ /___ /_____ Staff Member: _____ Notes: _____**