**NAME:**_____

**Parish Nursing Services** Phone #:_____

**Individual Blood Pressure Screening Form** Congregation:_____

| Date | Result Pulse | Result B/P* | Result B/P* | Result B/P* | Under MD care? | Follow-up? | Comments | Initials |
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* L – left arm, R – right arm, O--- lying, O – sitting, O – standing has record

Parish Nurse X_____ Signature/Initial _____

Signature/Initial _____ Signature/Initial _____

Circle when to follow-up (Month):

Jan Feb March April May June July Aug Sept Oct Nov Dec Jan Feb March April May June

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