McLaren
BAY REGION

Blood Pressure Screening

Name: _____ Age: _____ Date of Birth: ____/____/____

Address: _____ City: _____ Zip: _____

Phone: _____ Email: _____ Gender: ☐Male ☐Female

Name and Address of Your Primary Care Physician:

Name: _____ Phone: _____

Address: _____ City: _____ Zip: _____

Do you want McLaren Bay Region to send your screening results to your physician? ☐Yes ☐No

Consent & Release of Liability:
I hereby consent to participate in the blood pressure screening. I release McLaren Bay Region, and any other organizations or healthcare personnel associated with this screening from any and all liability arising from or connected with this screening. I understand that the result(s) of this screening is preliminary only and does not substitute a diagnosis. I also understand the responsibility for initiating a follow-up examination to confirm the result(s) of this screening and for obtaining professional medical assistance is mine alone.

I have read the consent form and understand it. Any questions which may have occurred to me have been answered to my satisfaction. If important facts about my personal health should be found, I realize it is my responsibility to present this information to my personal physician.

I realize that my signature indicates that I have agreed to participate in this health screening.

_____ _____
Participant Signature Date

Screening Examination (to be completed by screening staff):

Blood Pressure Measurement:

Left Arm: _____/_____ Systolic/Diastolic

Right Arm: _____/_____ Systolic/Diastolic

Results Classification:

	Systolic		***Diastolic***
____ Normal	Less than 120	and	Less than 80
____ Elevated	120 – 129	and	Less than 80
____ Hypertension: Stage 1	130 – 139	or	80 - 89
____ Hypertension: Stage 2	140 or higher	or	90 or higher
____ Hypertensive Crisis	Higher than 180	and/or	Higher than 120

Notes: _____

Screening staff signature: _____ Date: _____