**Community Pharmacy Hypertension Case-Finding Service – Referral form from GP practice to community pharmacy**

|  |  |
| --- | --- |
| To (pharmacy name) |  |
|  |
| **Patient name** |  |
| **Address** |  |
| **Patient DOB** |  | **NHS number** |  |
|  |
| I am referring this patient to you for: |
| * Their blood pressure to be measured (clinic check)
 | **[ ]**  |
| * 24-hour Ambulatory Blood Pressure Monitoring
 | **[ ]**  |
| Additional comments |
|  |
| GP name |  |
| GP practice name and address |  |
| Telephone  |  |

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