CITY OF *Lethbridge*

LETHBRIDGE FIRE DEPARTMENT BLOOD PRESSURE PROGRAM ASSESSMENT FORM

Please ensure all data fields are completed INCLUDING recommendation. Upon completion, put BP Assessment form in PCR tray for pick up. DO NOT FAX!

TO BE COMPLETED BY FIRE FIGHTER

Start Here ↓ **Surname**

Start Here ↓ **First Name** **Int**

Home Phone -

Date of Birth: **Year** / **Month** / **Day**

Gender ○ **Female** ○ **Male**

PLEASE ASK CLIENT THE FOLLOWING QUESTIONS:

HAVE YOU EVER BEEN TOLD BY A DOCTOR THAT YOU HAVE HIGH BLOOD PRESSURE? ○ **YES** ○ **NO**

ARE YOU TAKING BLOOD PRESSURE MEDICINE PRESCRIBED BY YOUR DOCTOR? ○ **YES** ○ **NO**

BY TAKING PART IN THIS BLOOD PRESSURE PROGRAM, I AM GIVING UP MY LEGAL RIGHT TO SUE THE CITY OF LETHBRIDGE OR ITS EMPLOYEES FOR DAMAGES OF ANY KIND THAT MAY BE CAUSED BY MY PARTICIPATION. I understand that this blood pressure measurement does not take the place of a physician's advice and that I may be referred for follow up by a physician or otherwise. It is my sole responsibility to pursue such a follow up.

I HAVE READ AND UNDERSTAND THIS WAIVER

CLIENT SIGNATURE: DATE:

ASSESMENT DATE: YEAR / MTH / DAY

ASSESSMENT LOCATION (STATION #)

EMPLOYEE NO.

FOLLOW UP RECOMMENDATION TO CLIENT

- ○ RECHECK IN 2 YEARS
- ○ RECHECK IN 1 YEAR
- ○ CONFIRM WITH DR. WITHIN 2 MTH (a)
- ○ DR. FOLLOW-UP CARE WITHIN 1 MTH
- ○ DR. FOLLOW-UP CARE WITHIN 1 WEEK
- ○ SEE DR. IMMEDIATELY

H.R.

	SYSTOLIC	DIASTOLIC
1ST READING		
2ND READING		
AVERAGE		

Averages should be rounded UP to even numbers.
NO ODD NUMBERS in readings.

COMMENTS:

The personal information collected on this form is in accordance with Section 33 of Alberta's Freedom of Information and Protection of Privacy Act (FOIP). Disclosure will be in accordance with Section 40 of the FOIP Act. If you have any questions in regards to the collection, use or disclosure of the information, please contact the Deputy Chief of Emergency Medical Services at (403) 320-3800.

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