Community Pharmacy Hypertension Case-Finding Service – Referral form from Optical or Dental practice to community pharmacy

To (pharmacy name)	

Patient name			
Address			
Patient DOB		**NHS number**	

I am referring this patient to you for:

- **Ambulatory Blood Pressure Monitoring (ABPM)** ☐
  Note to practice: Patients referred for an ABPM must be aged 40 years and over. Please provide their clinic blood pressure reading.

  Clinic blood pressure: /

  Date:

Additional comments

Practitioner name	
Practice name and address	
Telephone	

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