

## WISEWOMAN SMBP REFERRAL FORM



WISEWOMAN SELF-MONITORING BLOOD PRESSURE FAX REFERRAL FORM



### WISEWOMAN CENTRAL OFFICE

FAX 573-522-3023

**Provider Information:**

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Clinic Name: \_\_\_\_\_

Health Care Provider: \_\_\_\_\_

Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_

**Client Information:**

Client Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Home #: (\_\_\_\_) \_\_\_\_-\_\_\_\_ Cell #: (\_\_\_\_) \_\_\_\_-\_\_\_\_

Language Preference: \_\_\_\_ English \_\_\_\_ Other - \_\_\_\_\_

Client IS / IS NOT currently taking medications for hypertension

**WISEWOMAN Screening**

BP#1 \_\_\_\_/\_\_\_\_ BP#2 \_\_\_\_/\_\_\_\_

Average BP \_\_\_\_/\_\_\_\_

Weight \_\_\_\_ Smoker YES NO

Name of Medication & Dosage \_\_\_\_\_

Name of Prescribing Provider: \_\_\_\_\_

Client IS / IS NOT able to access medication.

Needs assistance in filling out Prescription Assistance Paperwork \_\_\_\_\_

Needs referral to a Prescription Assistance Program \_\_\_\_\_

Comments: \_\_\_\_\_

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