GP Practice Self Referral Form

Client details

Mr/Mrs/Ms/Miss
Forename(s):……..Surname:……..

Address:……Postcode……..

Daytime Contact number:……

D.O.B:…….

GP name and Address:……

Client identification number:…….

Dear Dr ……

☐ The above client attended the pharmacy on ……. after carrying out Home Blood Pressure Monitoring for one week. The results of this monitoring show an average blood pressure reading of ……. As this is above the threshold level, I would be grateful if you could review the attached results with the client for diagnosis and management as appropriate.

☐ The above client attended the pharmacy on ……. for a one off blood pressure reading. The results of this monitoring show a systolic/diastolic blood pressure reading of …….. I would be grateful if you could review these results with the client for diagnosis and management as appropriate.

☐ The above client attended the pharmacy on ……. for a one off blood pressure reading. The blood pressure monitor detected the potential presence of *Atrial Fibrillation/Low Blood Pressure with symptoms (*delete as appropriate). I would be grateful if you could review these results with the client for diagnosis and management as appropriate.

Many thanks for your help in this matter.

Pharmacist name……

Pharmacy address……

Pharmacy contact number……

Pharmacy stamp