HOME BLOOD PRESSURE ALERT FORM

Directions: The participant/family was provided an appropriate Blood Pressure (BP) threshold.

- >95th percentile + 12 mmHg for children aged <13 years old
- ≥140/90 mm Hg for children aged ≥13 years old to <18 years old
- ≥ 160/100 mm Hg for adults ≥18 years old

Complete this form if the site is notified by:

- the family/participant that the participant experienced any blood pressure related concerns (i.e., high BP readings above threshold, low BP readings, dizziness etc.) while using the Qardio home BP device.
- UCSF that the participant had a critically high BP average (i.e., the participant's average BP was above the appropriate BP threshold).

A1. KID #: |__| - |__|__| - |__|__|__|

A2. FORM COMPLETED BY (INITIALS): ___ ___ ___

A3. Date the coordinator was contacted: ___ ___ / ___ ___ / ___ ___ ___ ___

A4. Who contacted the coordinator?
☐ UCSF[1] **(Skip to Section C)**
☐ Family/participant[2]
☐ Both (UCSF and Family/Participant)[3]

Section B: Concern reported by Family/Participant

B1. Indicate the family/participant's concern:
☐ High and/or Low BP[1]
☐ Other[2] **(Skip to B4)**

Participant may have more than one high or low BP reading. Record the highest and/or lowest BP reading.

B2. High BP Reported *(Check box, if N/A* ☐[-1]*)*

a. Number of high BP readings: ___ ___

b. Highest BP: ___ ___ ___ / ___ ___ ___

c. Date of BP: ___ ___ / ___ ___ / ___ ___ ___ ___

B3. Low BP Reported *(Check box, if N/A* ☐[-1]*)*

a. Number of low BP readings: ___ ___

b. Lowest BP: ___ ___ ___ / ___ ___ ___

c. Date of BP: ___ ___ / ___ ___ / ___ ___ ___ ___

B4. Did UCSF contact site? ☐ Yes[1] ☐ No[2] **(Skip to Section D)**

Section C: Concern reported by UCSF (refer to UCSF Home BP Readings Quarterly Report)

C1. Number of readings above threshold: ___ ___

C2. Average BP (SBP/DBP): ___ ___ ___ / ___ ___ ___
Average SBP Average DBP

C3. Date of BP weekly summary: ___ ___ / ___ ___ / ___ ___ ___ ___

C4. Was the family/participant contacted* about the elevated BP readings alert? ☐ Yes[1] ☐ No[2]
*It is recommended that the family/participant is contacted within 24 hours after the site is notified.

Section D: Follow-up by site

D1. Did the participant experience any of the following symptoms during their week of readings? (Indicate "yes" or "no" for each of the following)

	Yes[1]	No[2]
a. Dizziness / Lightheadedness	☐	☐
b. Weakness	☐	☐
c. Headaches	☐	☐
d. Other, Specify: _____	☐	☐

D2. Was the participant's nephrologist/health care provider contacted? ☐ Yes[1] ☐ No[2]

i. Name of physician contacted: _____

ii. Date of contact: ___ ___ / ___ ___ / ___ ___ ___ ___

iii. Initials of staff who made contact: ___ ___ ___

Please scan and email the completed form to your Clinical Coordinating Center (CCC)

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