# HOME BLOOD PRESSURE ALERT FORM

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

- >95th percentile + 12 mmHg for children aged <13 years old
- ≥ 160/100 mm Hg for participants ≥13 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 alert level, dizziness etc.) while using the home BP device.

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

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

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

A4. Who contacted the coordinator? ☐ Family/participant[2] ☐ Other[3]

## Section B: Concern reported by Family/Participant

B1. Indicate the family/participant's concern: ☐ High BP[1]
☐ Other[2] **(Skip to C1)**

Participant may have more than one high reading. Record the highest BP reading.

B2. High BP Reported

a. Number of high BP readings: ___ ___

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

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

## Section C: Follow-up by site

C1. 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: _____ | ☐ | ☐ |

C2. Was the participant's nephrologist/health care provider contacted? ☐ Yes[1] ☐ No[2] **(END)**

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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