

Primary Care Strategies to Reduce High Blood Pressure: A Cluster Randomized Trial in rural Bangladesh, Pakistan and Sri Lanka

GP MANAGEMENT CHECKLIST

1	Date of diagnosis (dd/mm/yyyy)		6	Participant's name	
2	Date of birth (dd/mm/yyyy)		7	Community Household #	
	Age at last birthday		8	Name of provider	
3	Name of CHW		9	Designation of provider	
4	Blood pressure as indicated in the referral checklist (average of 2 readings)	SBP: _____ mm Hg DBP: _____ mm Hg	10	Clinic Address	
5	Number Assigned by CHW		11	Visit Type (eg. BL, 3m, 6m, 9m, ...)	
Study ID (if any): _ _ - _ _ - _ _ _ _ - _ _					

(1) Details of BP Reading at the current clinic visit:

BP Readings	1 st Reading	2 nd Reading
Time of BP Reading (hh:mm):		
Systolic BP (mm Hg):		
Diastolic BP (mm Hg):		
Pulse (beats per minute):		
<p>Is the current systolic BP below 140 mm Hg and diastolic BP below 90 mm Hg (Treatment Target) for persons aged <80 years?</p> <p><input type="checkbox"/> 1. Yes</p> <p><input type="checkbox"/> 2. No → <i>manage hypertension as per treatment algorithm</i></p>		

(2) Is the patient currently on an anti-hypertensive medication?

1. Yes → Indicate details below

2. No → Item #3

No.	Generic Name	Dosage	Frequency (# of times taken per day)	Medication Status
1	_____	_____ mg/tab		<input type="checkbox"/> 1. Newly started <input type="checkbox"/> 2. Dose titrated <input type="checkbox"/> 3. Dose maintained
2	_____	_____ mg/tab		<input type="checkbox"/> 1. Newly started <input type="checkbox"/> 2. Dose titrated <input type="checkbox"/> 3. Dose maintained
3	_____	_____ mg/tab		<input type="checkbox"/> 1. Newly started <input type="checkbox"/> 2. Dose titrated <input type="checkbox"/> 3. Dose maintained

(3) Does the patient have any of the following high CVD risk factors? *(Tick all check boxes that apply)*

- 1. Age ≥ 55 years and SBP ≥ 160 mm Hg
- 2. Diabetes Mellitus
- 3. History of heart disease
- 4. History of stroke
- 5. Current smoker

Prescribe **statin** if any of the above factors is present.

Name of statin prescribed	Dose of statin prescribed

(4) Any action taken during this follow-up clinic visit?

1. Yes

If **YES**, what are the action(s) taken? *(Tick all check boxes that apply)*

Advice on lifestyle modification strengthened

Advice on medication adherence strengthened

Anti-hypertensive medication prescribed

Statin prescribed

Other: _____

2. No (→ END)