HYPERTENSION CARE FLOW SHEET
This Flow Sheet is based on the Hypertension Guideline
Web site: http://www.bcguidelines.ca

NAME OF PATIENT

<table>
<thead>
<tr>
<th>SEX</th>
<th>DATE OF BIRTH</th>
<th>AGE AT DIAGNOSIS</th>
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<tbody>
<tr>
<td>M</td>
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<td>F</td>
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CARE OBJECTIVES

RISK FACTORS AND CO-MORBID CONDITIONS (NOTE: if patient also has DM and/or CHF, use respective flowsheet instead)

- Obesity
- Height (cm)

- CVD
- Dyslipidemia
- Kidney
- Review BP:
  - <140/90 no co-morbid conditions
  - 130/80 DM, renal disease or end organ damage

- Smoker
- Alcohol (assess/discuss)
- Gout
- Asthma
- Allergy: (e.g. ASA)
- Other:

- CVD
- Dyslipidemia
- Kidney
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- Allergy: (e.g. ASA)
- Other:

SELF MANAGEMENT (Discuss with patient)

- Explain the consequences of hypertension
- Review meds & adverse effects
- Smoking cessation: Quit Now
  - Phone toll free in BC: 1 877 455-2233
- Refer to guideline & patient guide
  - Set goals with patient (See reverse):
    - Promote weight loss & exercise
    - Avoid excessive alcohol
    - Reduce salt intake & improve diet
- Copy of Flow Sheet to patient if appropriate

- Other:

VISITS (3 TO 6 MONTHS)

<table>
<thead>
<tr>
<th>DATE</th>
<th>BP</th>
<th>WEIGHT</th>
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NOTES (REVIEW RISK FACTORS, GOALS, & CLINICAL STATUS.)

BP MEDICATION NOTES

BASELINE (Note allergies, side effects & contraindications)

*Consider low dose ASA if age 50-70 & ≥ 20% CHD risk

REMINDERS: 1) CONSIDER END ORGAN DAMAGE: EYES, HEART, CIRCULATION, KIDNEYS
2) SEE REVERSE FOR LIFESTYLE MANAGEMENT & TREATMENT RECOMMENDATIONS

LIPIDS

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<tr>
<th>DATE</th>
<th>TC</th>
<th>LDL</th>
<th>TC/HDL</th>
<th>%</th>
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TARGETS

- < 3.5
- < 5.0 MOD < 20%
- < 2.5
- < 4.0 HIGH > 20%

FRAMINGHAM 10-YR RISK

KIDNEY

<table>
<thead>
<tr>
<th>DATE</th>
<th>ACR</th>
<th>eGFR</th>
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TARGETS

- M < 2.0
- F < 2.8
- > 60

CONSIDER TESTING EVERY SECOND YEAR IF LESS THAN 10% CHD RISK

VACCINATIONS (If ≥ age 65 or has other risk factors)

- Annual Flu:
  - DATE
  - DATE
  - DATE

- Pneumovax:
  - DATE
  

BILLING CODE: 14052  DIAGNOSTIC CODE: 401  BILLING: DATE  DATE
Lifestyle Management for Patients with Hypertension

Suggestions for the following lifestyle changes should be offered and reviewed at each visit:

**Smoking cessation**
Recommend complete cessation of smoking and exposure to second hand smoke.
BC Smokers Helpline: 1-877 455-2233 (toll-free in B.C.) 10 AM-6 PM, and www.quitnow.ca.

**Physical activity**
Prescribe 30-60 minutes of moderate intensity dynamic activity (such as walking 2 miles in 30 minutes once per day, or 1 mile in 15 minutes two times per day, jogging, cycling or swimming) 4-7 days per week. Recommend getting a pedometer for immediate positive feedback.

**Weight reduction**
All overweight patients with hypertension should be advised to lose weight. Weight loss strategies should be long-term and employ a multidisciplinary approach that includes dietary education, increased physical activity, and behavioural intervention. Target: body mass index (BMI) 18.5-24.9 kg/m², waist circumference <102 cm for men and <88 cm for women.

**Dietary recommendations**
Advise a diet high in fruits, vegetables, low-fat dairy products, dietary and soluble fibre, whole grains and protein sources reduced in saturated fats and cholesterol (Dietary Approaches to Stop Hypertension (DASH) diet). Reduce consumption of trans-fats and increase intake of fish that is high in omega 3 fatty acids.

**Reduce salt intake**
Recommend reduced dietary sodium intake of ≤ 1,500 milligrams per day (approximately 1 tsp of table salt).

**Alcohol consumption**
Limit to two drinks or less per day, and consumption should not exceed 14 standard drinks per week for men and 9 standard drinks per week for women.

**Potassium, calcium and magnesium intake**
Supplementation of potassium, calcium and magnesium is not recommended for the prevention or treatment of hypertension.

**Pharmacologic Treatment without Co-morbid Conditions**

The benefits of pharmacologic treatment in people with mild hypertension (average BP between 140/90 and 160/100), and a 10-year coronary heart disease risk of less than 20%, are unclear. Use clinical judgment when recommending therapy for this patient group.

Pharmacologic treatment, in addition to lifestyle modification is recommended for patients with an average BP ≥ 160/100, even in the absence of other major cardiovascular risk factors.

Consider monotherapy with a low-dose thiazide diuretic as first-line treatment.

If BP is not controlled, use combination therapy by adding 1 or more of:
- ACEI or ARB if ACEI intolerant
- Long-acting dihydropyridine calcium channel blockers (CCB (DHP))

Note:
- Long-acting CCB (DHP) are preferred 2nd line treatment for patients at risk for, or with a history of, stroke
- Beta blockers may no longer be a first line treatment option, with some exceptions (guideline under revision)
- Alpha blockers are not a 1st line treatment option

Consider addition of low-dose ASA therapy if Framingham risk score is ≥ 20% and patient is between 50 to 70 years-of-age. Avoid using ASA in patients with a history of hemorrhagic stroke. Exercise extreme caution if blood pressure is not controlled.

See hypertension guideline for pharmacologic management if co-morbid conditions exist.