

Patient: _____ DOB: _____ Date: _____



TEAM ACTION PLAN (TAP) -- Visit 1

A. HTN medications		B. Co-morbidities and JNC Goal	
1.		<input type="checkbox"/> diabetes <input type="checkbox"/> heart failure <input type="checkbox"/> kidney disease <input type="checkbox"/> ischemic heart disease (stable angina or MI) JNC goal: <input type="checkbox"/> < 130/80 mm Hg <input type="checkbox"/> < 140/90 mm Hg	
2.			
3.			
4.			
C. Blood Pressure	BP on enrollment date: _____	BP today: _____ Staff initials: _____	
D. Assessment of HTN-related Issues. PATIENT has...			
<input type="checkbox"/> uncontrolled blood pressure <input type="checkbox"/> adherence problem (missed doses, late refills, other) <input type="checkbox"/> misconception or doubt re drug regimen, purpose, or effects <input type="checkbox"/> bothersome side effects <input type="checkbox"/> difficulty paying for medication <input type="checkbox"/> difficulty remembering medication		<input type="checkbox"/> low awareness of BP goal <input type="checkbox"/> low physical activity (< 30 min on most days) <input type="checkbox"/> high sodium intake <input type="checkbox"/> weight problem (BMI \geq 25) <input type="checkbox"/> interest in adjusting or changing drug therapy <input type="checkbox"/> interest in making lifestyle change(s)	
Notes:			
E. Plan			
<input type="checkbox"/> Explained drug regimen, purpose, and/or effects <input type="checkbox"/> Discussed options for managing side effects <input type="checkbox"/> Discussed options for reducing drug costs <input type="checkbox"/> Reinforced importance of adherence and tips for remembering <input type="checkbox"/> Patient will try pill organizer <input type="checkbox"/> Patient will return for BP monitoring <input type="checkbox"/> Patient referred to doctor for evaluation <input type="checkbox"/> Report will be sent to prescriber <input type="checkbox"/> other		<input type="checkbox"/> Educated about BP goal and monitoring <input type="checkbox"/> Counseled on exercise <input type="checkbox"/> Counseled on sodium <input type="checkbox"/> Other dietary counseling <input type="checkbox"/> Patient's goal(s) for next month:	
Notes:			
Pharmacist Signature:		Pharmacist Intervention Time (do not include tech time)	
		<input type="checkbox"/> 1-9 min <input type="checkbox"/> 10-19 min <input type="checkbox"/> 20-29 min <input type="checkbox"/> \geq 30 min	