CHAP
Cardiovascular Health Awareness Program
Programme de sensibilisation à la santé cardiovasculaire

Appendix 4.2

Family Physician Letter of Understanding

I agree to participate in the Cardiovascular Health Awareness Program (CHAP). I understand that CHAP is a community-based program involving cardiovascular disease and stroke risk factor assessment including blood pressure measurement, with customizable reports sent directly to family physicians.

I understand that CHAP targets patients who are at high-risk but not diagnosed with hypertension or have uncontrolled hypertension.

I understand that CHAP sessions are operated by Volunteer Peer Health Educators who are trained by a Community Health Nurse. During CHAP sessions, these volunteers will help to measure and record my patients' blood pressure using an automated blood pressure measuring device and will help my patients to complete a cardiovascular disease and stroke risk profile. With the patient's permission, the volunteers forward blood pressure readings and risk profiles to a computerized database which, in turn, sends the information to me. A copy of the blood pressure reading and risk profile is also given to each patient and to his/her regular pharmacist (with the patient's permission). I will follow up with patients, where appropriate.

I understand that a community health nurse is on-call during the CHAP sessions. A CHAP Session Blood Pressure Recommendation Protocol developed in consultation with family physicians is used to guide reassessment and/or referral of patients with very high or low blood pressure readings. Volunteers use this protocol to determine if the community health nurse should be contacted. A CHAP Session Blood Pressure Recommendation Protocol has been attached for your information.

As a participating physician, I have chosen to:

❑ Use RECOMMENDED OPTION 1: Personalized Invitation letters, signed by the family physician
If I choose to invite my patients via personalized letter, I will work with CHAP staff to create an electronic mailing list for my high-risk patients.
A CHAP session schedule will be sent with the letters.

❑ Use OPTION 2: Community-wide advertising
A schedule of sessions will be publicized in local media and newsletters, and posted in physicians' offices, local pharmacies, and public buildings.

I understand that only aggregate data will be reported in CHAP reports and publications. Data collected for CHAP will be kept secure and confidential and will not be given to any other person(s) or organization(s).

If I have any further questions, I can contact name, Local CHAP Coordinator, at XXX-XXXX.

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Name of Physician (Please Print)

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Signature of Physician ***Date***