Print Reset

BLOOD PRESSURE RECHECK

To be completed by the applicant's attending physician

ATTENDING PHYSICIAN/APPLICANT INFORMATION

NAME OF ATTENDING PHYSICIAN

ADDRESS OF ATTENDING PHYSICIAN

NAME OF APPLICANT

DATE OF BIRTH DAY MONTH YEAR

DETAILS

1. Please take 3 or more blood pressure readings, preferably at 5 minute intervals.

SYSTOLIC _____ _____ _____ _____ _____

DIASTOLIC (at cessation of sound) _____ _____ _____ _____ _____

2. Has the applicant:

(a) Ever been told that his/her blood pressure has been elevated?

☐ YES ☐ NO If "YES", please provide details, including dates, type of therapy and names of doctors consulted).

(b) Ever received treatment for blood pressure?

☐ YES ☐ NO If "YES", please provide details, including dates, type of therapy and names of doctors consulted).

3. **If the applicant has had an electrocardiogram, please attach a copy.**

SIGNATURE

A photocopy or an electronic reproduction of this document will be as valid as the original.

Attending Physician's Signature: _____ Date: _____

PLEASE RETURN FORM TO:
Western Life Assurance, 400-200 Main Street, Winnipeg, MB R3C 1A8, TEL: 1-888-647-5433, FAX: 1-877-783-6913

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