ID: _____

Date: ____ / ____ / _____

Safety Review Form

This form should be filled out by clinic or intervention staff if the participant calls in to report a medical problem, or mentions a medical problem at an intervention visit. The form should then be reviewed by the site clinician to determine whether any follow-up with the participant needs to occur.

Briefly describe event (Indicate whether it is ongoing or resolved):

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Clinician Review:	**Yes**	**No**	**N/A**
Does this condition require that the participant's intervention participation be modified? (*If "yes", complete next page)*	❑	❑	❑

_____ _____

Clinician signature Date

Reviewed by (staff ID): _____

To be completed by site clinician if participant's intervention participation is modified:

	Yes	No	DK
1. Study-related consequences of event.....change in diet	❑	❑	❑
change in current exercise pattern	❑	❑	❑
started on BP medications	❑	❑	❑
interrupted intervention attendance	❑	❑	❑

	Yes	No
2. Has the participant seen their physician as a result of this event?	❑	❑
If No: Was participant referred to their physician as a result of this event?.....	❑	❑

3. Site clinician notes (Optional):

_____

_____

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