

**FULL TEXT REVIEW FORM****Name of reviewer** \_\_\_\_\_**Date of review** \_\_\_\_\_**A. Article Information**

1. ID number \_\_\_\_\_

2. Author \_\_\_\_\_

3. Title \_\_\_\_\_

4. Year \_\_\_\_\_

**B. Included in this review for (may be more than one):**

- ☐ Reproducibility of same measure                      How far apart? \_\_\_\_\_
- ☐ Comparison of clinic to ambulatory
- ☐ Comparison of clinic to home
- ☐ Comparison of home to ambulatory
- ☐ Comparison of clinic to automated office
- ☐ Comparison of automated office to ambulatory

**C. Were clinic/office measurements made using mercury device?** \_\_\_\_\_ *If yes, clinic/office measures are not eligible for inclusion in this review.*

**D. Population of the Study****1. Country of study****2. Age** (specify mean age if noted)**3. Sex % female****4. Racial/ethnicity representation****5. Any other important details about the population****6. Inclusion criteria****7. Exclusion criteria**

**8. Setting for monitoring** (office/ clinic reading)

Primary care

Secondary care

Research visit

Other (specify)

**E. Quality of the Study****1. What was the sampling frame?**

General population

Primary care

Specialty care

Specify details of the subgroup if relevant

**2. How were the participants selected?**

Consecutively

Randomly

Other (specify)

Unclear

**3. What was the planned vs actual sample size?****4. Data on drop-outs (if any)****5. Design of study**

Cross-sectional

Repeated-measures

Other design (please specify)

**6. Did either the whole sample, or a random selection of the sample, receive the same comparison measurement tests?**

Yes    No    Unclear

**7. Were participants subject to the same comparison measurement tests regardless of the result of the initial measurement test?**

Yes    No    Unclear

**8. Were those taking BP measurements blinded to the previous results of BP monitoring?**

Yes    No    Unclear

**9. Were participants blinded to the previous results of BP monitoring/measurements?**

Yes    No    Unclear

**10. Were uninterpretable measurement results reported (to avoid exclusion bias)?**

Yes    No    Unclear

#### **F. Details of the comparisons**

	Clinic	Home	Ambulatory	Other
<b>Number of measurements</b>				
<b>Type of monitor</b>				
<b>Monitor validated?</b>				
<b>Time of day (for ABPM, define awake period)</b>				
<b>Arm used</b>				
<b>Who performed measurements</b>			N/A	
<b>Mean of measurements</b>				
<b>Cutoff for hypertension</b>				

**G. DATA TABLES****REPRODUCIBILITY**

**ABPM**              **Home**              **Clinic**              **Other** \_\_\_\_\_              \_\_\_\_\_ **weeks apart**

	<b>Yes</b>	<b>No</b>	<b>TOTAL</b>
<b>Yes</b>			
<b>No</b>			
<b>TOTAL</b>			

**Percent agreement(s)**

**Kappa(s)**

**CLINIC VS HOME**

<b>DX:</b>		<b>Clinic Threshold:</b>		
		<b>Yes</b>	<b>No</b>	<b>TOTAL</b>
<b>Home Threshold:</b>	<b>Yes</b>			
	<b>No</b>			
	<b>TOTAL</b>			

**Sensitivity**

**Specificity**

**CLINIC VS ABPM**

<b>DX:</b>		<b>Clinic Threshold:</b>		
		<b>Yes</b>	<b>No</b>	<b>TOTAL</b>
<b>ABPM Threshold:</b>	<b>Yes</b>			
	<b>No</b>			
	<b>TOTAL</b>			

**Sensitivity**

**Specificity**

**HOME VS ABPM**

DX:		Home Threshold:		
		Yes	No	TOTAL
ABPM Threshold:	Yes			
	No			
	TOTAL			

Sensitivity

Specificity

**CLINIC OR ABPM (CIRCLE ONE) VS AUTOMATED OFFICE**

DX:		Clinic or ABPM Threshold:		
		Yes	No	TOTAL
AO Threshold:	Yes			
	No			
	TOTAL			

Sensitivity

Specificity

\_\_\_\_\_ VS \_\_\_\_\_

DX:		Home Threshold:		
		Yes	No	TOTAL
ABPM Threshold:	Yes			
	No			
	TOTAL			