Self-measured blood pressure monitoring

Program Agreement

PATIENT INFORMATION:

Name: ____ Date of Birth:___________________

Preferred Contact Information (Phone or Email):____

Patient's self-measured blood pressure monitoring device is: ☐ Patient Owned ☐ Borrowed from Lowell CHC

FOR OFFICE STAFF

LENDER INFORMATION

Lowell Community Health Center
161 Jackson Street, Lowell MA, 01854
978.937.9700

EQUIPMENT INFORMATION

Device manufacturer and model:

____

Device ID:___________________________

Supplies Provided (check all that apply): BP Cuff

- ☐ Carrying case
- ☐ Power cord
- ☐ Batteries
- ☐ Other_______________________

Return by: _________/__________
Month / Year

- ☐ I agree to participate in the self-measured blood pressure device loaner program and follow the guidelines given to me.
- ☐ I agree to return this device in good, working condition on or before its due date (for patients borrowing a Lowell CHC device).
- ☐ My participation in this program is voluntary and is not a substitute for comprehensive medical care.
- ☐ I understand that readings from this self-measured blood pressure device are not monitored in real time by Lowell Community Health Center staff and providers and I have been instructed on how and when to report abnormal results.

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Patient Signature **Date**

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Dispensing Staff Member **Date**