Blood Pressure Monitor Agreement Form

Clinic Site: _____ BP Monitor NEVHC Number: _____

The goal of this agreement is to support and empower the patient to use their Blood Pressure Monitor on a regular basis in order to improve blood pressure control.

I, the **patient**, agree to do the following:

1. Use my blood pressure monitor as instructed by my NEVHC Care Team member.
2. Record my results in a paper blood pressure record (log).
3. Share with my Provider or Care Team member my results in real-time during a telehealth (video) or telephone visit (if applicable).
4. Contact my NEVHC Care Team member if my results are abnormal.

The NEVHC Care Team member agrees to do the following:

1. Encourage my patient to use their device at our regularly scheduled appointments so that they can improve their blood pressure.
2. Ensure my patient receives education on how to use their Blood Pressure Monitor.

I have read and understand the terms listed above. I have asked any questions that I may have. I agree to follow this agreement, and understand what can happen if I do not.

My preferred method of contact is (check all that apply):

☐ Phone ☐ E-mail

Participant Name (Print) Signature of Participant Date

TO BE COMPLETED BY NEVHC CARE TEAM MEMBER

Patient was instructed on how to use the Blood Pressure Monitor and the patient was able to demonstrate understanding of the instruction.

☐ YES

☐ NO, I scheduled the patient for a blood pressure monitor instruction with Health Education on ____/____/____

Care Team Member Name (Print) Signature

Northeast Valley Health Corporation
a californiahealth+ center

(Affix Label)

Name:

M/R:

DOB:

Phone:

Date:

Formulario de Acuerdo del Monitor de Presión Arterial

Clinica: _____ BP Monitor NEVHC Number: _____

La meta de este acuerdo es para apoyar y capacitar al paciente sobre el uso del Monitor de Presión Arterial con regularidad para un mejor control de su presión arterial.

Yo, el **paciente**, acepto hacer lo siguiente:

1. Usar mi monitor de presión arterial como me indico el miembro de mi Equipo de Cuidado de NEVHC.
2. Anotar los resultados en mi diario de registro de presión arterial.
3. Compartir con mi Proveedor o miembro de mi Equipo de Cuidado los resultados durante mi visita por teléfono o video (si es aplicable).
4. Contactar al miembro de mi Equipo de Cuidado de NEVHC si mis resultados son anormales.

El miembro del Equipo de Cuidado de NEVHC acepta hacer lo siguiente:

1. Animar a mi paciente para que use su maquina en nuestras citas programadas regularmente para un mejor control de su presión arterial.
2. Asegurar que mi paciente reciba educación sobre el uso del Monitor de Presión Arterial.

Confirmo que he leído y entendido los términos listados arriba. He hecho las preguntas necesarias. Yo acepto seguir este acuerdo, y entiendo lo que puede pasar si no lo cumplo.

Mi método de contacto preferido es (marque los que apliquen):

☐ Teléfono ☐ Correo Electrónico

Nombre (letra de molde) Firma del Participante Date/Fecha

TO BE COMPLETED BY NEVHC CARE TEAM MEMBER

Patient was instructed on how to use the Blood Pressure Monitor and the patient was able to demonstrate understanding of the instruction.

☐ YES

☐ NO, I scheduled the patient for a blood pressure monitor instruction with Health Education on ____/____/____

Care Team Member Name (Print) Signature

Northeast Valley Health Corporation
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(Affix Label)

Name:

M/R:

DOB:

Phone:

Date: