PATIENT CONSENT FORM

Remote Patient Monitoring (RPM)

You have been invited to participate in our remote patient monitoring program using WCR Advantage™ from Wound Care Resources. This RPM program includes monitoring of your ventricular assist device and vital signs remotely. The data collected from your home monitoring devices will be securely transmitted to your healthcare team for review and assist them in making timely clinical decisions in your treatment plan more effectively. You may be asked to perform regular tests and measurements, as outlined by your LVAD care team.

By signing this consent form, you acknowledge the following:

- You have been fully informed about the nature and function of the RPM program.
- You consent to the collection, use, and transmission of your health data for monitoring and treatment purposes in a safe and secure manner in accordance with HIPAA and other applicable privacy laws.
- You agree to work collaboratively with your healthcare team to ensure the best possible care and outcomes.
- You understand you will be responsible for performing regular tests at home using the testing devices provided.
- Data collected from the devices will provide qualified health care professionals with more information related to my medical conditions. You may be contacted by phone or text to review and discuss results with your LVAD care team.
- You will notify your healthcare team immediately if you experience any health-related concerns that are not related to your monitoring program (for example, pain, swelling, dizziness, or other symptoms).
- **Remote patient monitoring is not a 24-hour monitoring service. If you are experiencing a medical emergency, please call 911 or proceed to the nearest emergency room.**
- You understand the risks and benefits associated with participation in the program.
- You are aware that you have the right to withdraw from the RPM program at any time without affecting your ability to receive medical care or treatment.
- You are the only person who should use the devices provided by the RPM program.

Patientl Name:	Patientl Signature:	Date:
FOR HEALTHCARE PROVIDER USE ONLY		
Healthcare Provider Name:	Healthcare Provider Signature:	Date:

Please note: These device are intended for use under medical supervision from your physician and results will be monitored by your LVAD care team. Do not make any changes in your treatment plan without consulting your physician for direction. If you are unable to reach your physician or LVAD care team, for any medical emergencies, call 911 or go to the nearest emergency room.