

PATIENT CONSENT FORM

Remote Patient Monitoring (RPM) With International Normalized Ratio (INR) Testing for Blood Clotting Time

You have been invited to participate in our remote patient monitoring program using WCR Advantage™ LVAD Remote Patient Monitoring and Supply Program from Wound Care Resources. This RPM program includes monitoring of your ventricular assist device, vital signs, and Prothrombin Time (PT)/INR levels 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 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, including the INR monitoring.
- 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. I may be contacted by phone or text to review and discuss my results.
- You may be contacted by phone or text to review and discuss your results with your LVAD care team.
- **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.

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