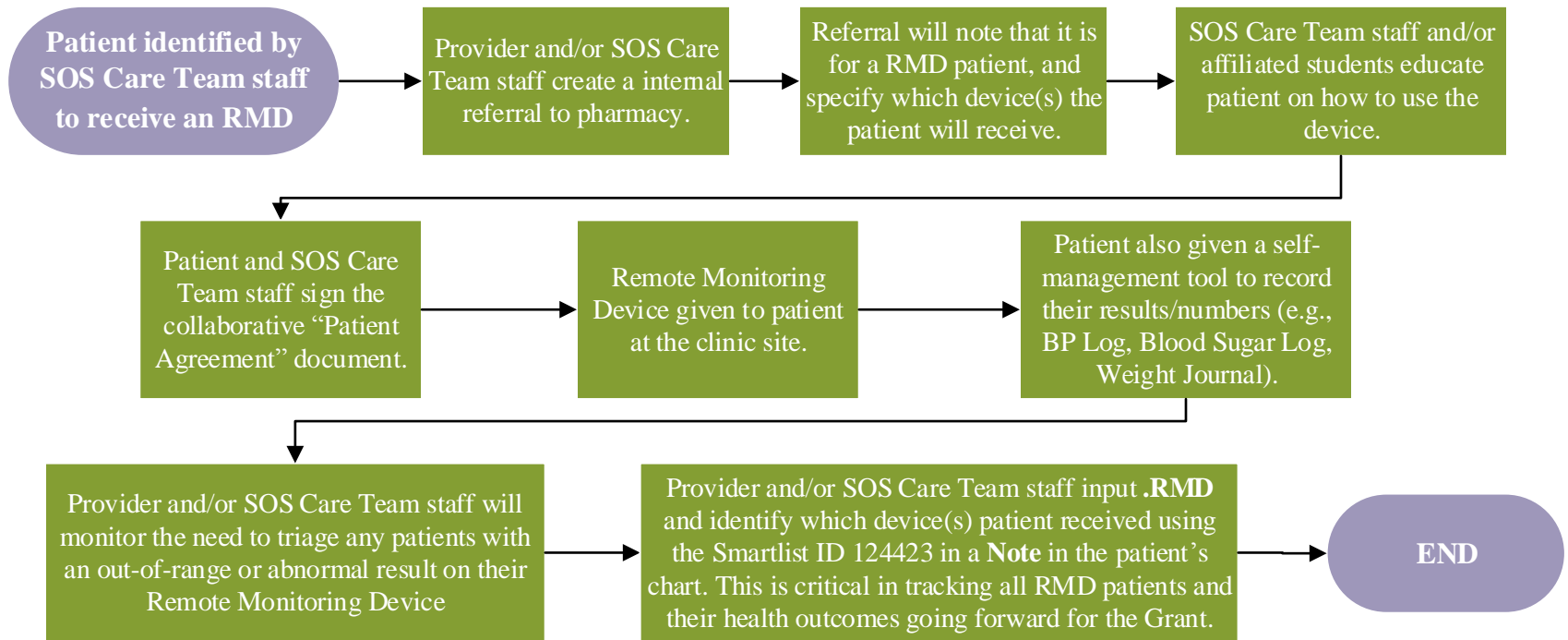
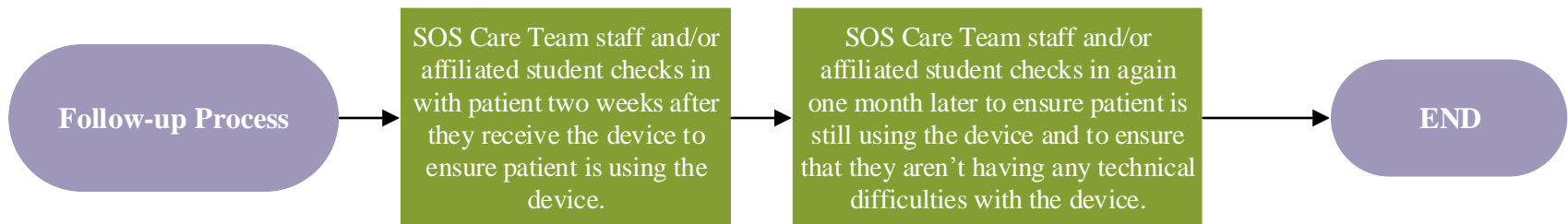


SOS Remote Monitoring Device (RMD) Distribution Workflow

SOS Care Team Staff Member



SOS Care Team Staff Member and/or Affiliated Student



Patient Care Agreement - Remote Monitoring Device

Share Our Selves Community Health Center



This agreement is between _____ and _____.
Patient Name **Care Team staff member name**

The goal of this agreement is to ensure that the patient uses their Remote Monitoring Device on a regular basis in order to improve their health outcomes.

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

1. Use my medical device as instructed by my Share Our Selves (SOS) Care Team staff.
2. Record my results in the app, or maintain a paper record (log).
3. Show my Provider or Care Team staff member my results in real-time during a Telehealth visit (if applicable).
4. Be present for my two check-ins with an SOS Care Team staff member.
5. Contact my SOS Care Team staff member if my results are abnormal.

The SOS Care Team staff agrees to do the following:

1. Encourage my patient to use their device at our regularly scheduled appointments so that they can improve their health outcomes.
2. Educate my patient on how to use their Remote Monitoring Device.
3. Check-in with my patient at least twice in the first two months of them receiving their device.

If I, the **patient**, do not follow the terms of this agreement, my SOS Care Team staff member may ask that I return the Remote Monitoring Device.

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.

Patient Signature

Date

SOS Care Team Staff Signature

Date

| VERBAL/NON-VERBAL INFORMED CONSENT CONSENTIMIENTO VERBAL O POR ESCRITO PARA RECIBIR TRATAMIENTO | |
|---|--|
| This informed consent was read on ESTE CONSENTIMIENTO HAS SIDO LEIDO EL DIA _____ | to: A: _____ |
| Name NOMBRE _____ | Signature Of Person Taking Consent FIRMA DE LA PERSONA QUE RECIBIO EL CONSENTIMIENTO |
| Date of Birth FECHA DE NACIMIENTO _____ | |
| Interpreter INTERPRETE _____ | Witness Signature - Optional FIRMA DEL TESTIGO - OPCIONAL |

