The Cuff Kit

brought to you by PREECLAMPSIA FOUNDATION
www.preeclampsia.org

PROVIDER FORM

Please verify that all the information on this form is correct and that all fields have been completed. If you need assistance from the Missouri Hospital Association please contact KHussey@mhanet.com.If you have any questions for the Preeclampsia Foundation, please contact Jennifer.Sea@preeclampsia.org or via phone at 800-665-9341.

MAIN POINT OF CONTACT

Organization/Company Placing Order: _____

Point of Contact Name: _____ Phone Number: _____

Alternate Phone Number: _____ Email: _____

Address (Street / Suite Number): _____

City: _____ State: _____ Zip Code: _____

SHIPPING POINT OF CONTACT (if different from above)

Organization/Company Placing Order: _____

Point of Contact Name: _____ Phone Number: _____

Alternate Phone Number: _____ Email: _____

Address (Street / Suite Number): _____

City: _____ State: _____ Zip Code: _____

CONFIRM CUFF KIT ORDER

- Total Number of Cuff Kits Needed (minimum quantity is 50): _____
- What percentage **or** number of the total number of kits are needed for "morbidly obese" patients (upper arm circumference greater than 17")? _____

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PARTICIPANT AGREEMENT

☐ By checking this box, you signify agreement that all participating sites agree to:

1. Utilize telehealth technologies to communicate with participating patients.
2. Give patients the entire Cuff Kit package (device, batteries, and envelope with instructions and patient information).
3. Prioritize distribution to patients at highest risk, especially vulnerable women with lower ability to procure their own BP cuff (i.e., Individual risk factors include chronic hypertension, history of preeclampsia, obesity, age (35+), autoimmune disorders [see complete list here]; as well as population-level risk factors such as black, Native American, or rural women).
4. Commit to providing feedback so we can assess the impact of this initiative. This will consist of providing a *quarterly* report to us indicating: a) total number of patients who received kits, their ages, race/ethnicity, and which trimester they were in when they received their kit; b) report either generally or, if possible, specifically how many patients used their BP logs and shared that information with her healthcare provider prenatally and/or postpartum; c) some sense of whether the BP readings the patients took for themselves informed or assisted the providers' management of her pregnancy (or postpartum health); and d) any challenges to implementing the program.

Signature of person responsible for this form: _____

Name: _____

Title: _____

Date: _____

HEALTH CARE DISCLAIMER: This program, related materials and services do not constitute the practice of medical advice, diagnosis or treatment. Always talk to your health care provider for diagnosis and treatment, including your specific medical needs. If you have or suspect that you have a medical problem or condition, please contact a qualified health care professional immediately. If you are in the United States and experiencing a medical emergency, call 911 or call for emergency medical help immediately.