

# The Cuff Kit



## ORDER FORM

Please verify that all the information on this form is correct and that all fields have been completed. If you have any questions, please contact [Jennifer.Sea@preeclampsia.org](mailto:Jennifer.Sea@preeclampsia.org) or via phone at 800-665-9341.

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### 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: \_\_\_\_\_

### BILLING POINT OF CONTACT TO RECEIVE INVOICE (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: \_\_\_\_\_

### PAYMENT INFORMATION

How will payment be made?

Credit Card

Check

Wire Transfer

Internal Order Number / PO if needed \_\_\_\_\_

### CUFF KIT ORDER

Total Number of Cuff Kits Needed (minimum quantity is 50): \_\_\_\_\_ Or the amount of funding you have secured (used to calculate # of kits we can provide): \_\_\_\_\_

- What percentage or number of the total number of kits are needed for “morbidly obese” patients (upper arm circumference greater than 17”) ? \_\_\_\_\_

How many participating sites will receive kits from this order? \_\_\_\_\_

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Please send an email with the included Excel spreadsheet to [Jennifer.Sea@preeclampsia.org](mailto:Jennifer.Sea@preeclampsia.org) with **contact name, phone number, and shipping address for each participating site, and quantity needed at that site**. We will be contacting those on site coordinators for any remaining details. You will receive a confirmation email and invoice once that information has been received. Please note whether we will be shipping directly to those locations or to a central location for distribution. Each provider will need to sign a separate provider agreement form

## 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.