**[Insert pharmacy name]**

**[Insert pharmacy address]**

**Ambulatory Blood Pressure Monitoring Device Loan Agreement**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Patient’s details** | | | | | |
| **Name:** |  | | | | |
| **Address:** |  | | | | |
| **Postcode:** |  | | **Phone Number:** |  | |
| **Equipment to be loaned** | | | | | |
| **Device Manufacturer & Model:** | |  | | **Serial number:** |  |
| **Items included (tick all that apply):** | | BP cuff  Carrying case  Power cord | | Batteries  Other: | |
| **Date of provision:** | |  | **Return by date:** |  | |

**I acknowledge:**

* The equipment is loaned by the pharmacy to enable 24-hour ambulatory blood pressure monitoring.
* The patient must return the equipment to the pharmacy to receive the clinical results.
* After the loan period of 24 hours, unless a longer period is agreed with the pharmacy, the pharmacy should be able to make the equipment available to other patients.
* Any delay in return of the equipment restricts the availability of the service to other patients.
* The pharmacy retains ownership of the equipment at all times.

**I agree:**

* To receive ambulatory blood pressure monitoring and follow the advice given to me by the pharmacist.
* To be responsible for the safekeeping of the equipment.
* To be the only person who uses the equipment.
* To notify the pharmacy as soon as reasonably practicable of any defect, failure or problem with the equipment.
* To return the equipment to the pharmacy in good working condition.
* To return the equipment on the return by date during the pharmacy’s opening hours.

I the patient, acknowledge and agree to the above statements;

I agree to receive ambulatory blood pressure monitoring and follow the guidelines given to me; and

I agree to return the device in good working condition on or before the due date.

**Patient signature:** **Date:**