Linlithgow Group Medical Practice

INHEALTH CARE OPT IN FORM: BLOOD PRESSURE MONITORING

Patient Name:
CHI Number:
Preferred Method of Communication:
SMS
EMAIL
HOME TELEPHONE
CONTACT NUMBER:
Or
EMAIL ADDRESS
I have read the information given to me and I give my consent to be signed up to the Inhealth Care Blood Pressure Monitoring system:
Patient Signature: