Patient Consent Form

Medicines Access Programs - SA

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Local Health Network / Health Service: | |  | | Hospital: | | |  | | | UR # |  |
| I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (name) hereby consent to the medicine \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (medicine name) to be administered to me under the specified Medicines Access Program. | | | | | | | | | | | |
| Program Name: | | |  | | | | | | | | |
| Start date: | | |  | | Stop date: | | | |  | | |
| *Please tick the following boxes:* | | | | | | | | | | | |
|  | I have been given clear information, both verbal and an information sheet, by Doctor \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_on the reason for using the medicine, its known effects and possible risks, and that the medicine is not routinely available from the Local Health Network / health service, and that continuing supply is dependent upon continuance of the Medicines Access Program at the Local Health Network, hospital or health service. | | | | | | | | | | |
|  | I have had an opportunity to ask questions relating to the treatment and discussed alternative treatments. | | | | | | | | | | |
|  | Doctor \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_has advised me of any potential conflict of interest he/she has in relation to the Medicines Access Program. | | | | | | | | | | |
|  | I consent to my doctor/the Local Health Network, hospital or health service disclosing information about my treatment with the medicine to the pharmaceutical company administering the program that is reasonably necessary for the company to be able to be able to properly assess the performance of the medicine. | | | | | | | | | | |
|  | I understand that the usual Local Health Network, hospital or health service medication dispensing charges will apply to all items supplied under the Medicines Access Program. | | | | | | | | | | |
| **Signed:** | |  | | | | **Signed:** | |  | | | |
| **Patient/ Agent Name:** | |  | | | **Witness Name (if needed):** | | |  | | | |
| Date: | |  | | | | Date: | |  | | | |