The Pharmacy Guild of Australia

HealthConsult
Better thinking. Better advice.

CONSENT FORM:
PATIENT

Chronic Pain MedsCheck Trial

FOR PATIENTS PARTICIPATING AT GROUP A OR B PHARMACIES

Medicare Number: _____

I, _____,
agree to take part in the Chronic Pain MedsCheck Trial.

In giving my consent I state that:

- I am 18 years of age or more
- I have read the Participant Information Statement and have been able to discuss my involvement in the trial with the pharmacist and/or Pharmacy Guild of Australia or the evaluation team if I wished to do so.
- The pharmacist and/or Pharmacy Guild and/or evaluators have answered any questions that I had about the trial and I am happy with the answers.
- I understand the purpose of the trial, what I will be asked to do, and any risks and benefits involved.
- I freely consent to participate in this trial according to the conditions in the Participant Information Sheet.
- I have been given a copy of the Participant Information Sheet to keep.
- I give permission for the pharmacist to contact my doctor and collaborate with other health professionals.

I understand that:

- The evaluation team may ask for access to my Medicare and PBS Data for trial analysis purposes. I understand that an additional signed consent form is required for Medicare and/or PBS Data to be obtained.
- The evaluation team may contact me up to 6 months after the initial consultation to conduct a follow-up survey.

I also understand that:

- Being in this trial is completely voluntary and I do not have to take part. My decision whether to be in the trial will not affect my relationship with my pharmacist, my GP, the Pharmacy Guild of Australia or the evaluation team.
- I can withdraw from the trial at any time and no further data will be collected. Any data already collected will be included in the trial unless I ask for it to be removed.
- Personal information about me that is collected over the course of this trial will be stored securely and will only be used for purposes that I have agreed to. Information collected about me will not be shared with others without my permission, except as required by law.
- The results of this trial may be published, and all publications will not contain my name or any identifiable information about me.
- At the end of the trial, information collected about me will be de-identified, marked confidential, and stored in a secure location.

For the purpose of follow-up

I consent to:

• Contact by phone	☐ Yes	☐ No
– A message may be left on voicemail	☐ Yes	☐ No
– A message may be left with another person	☐ Yes	☐ No
• Contact by sms	☐ Yes	☐ No
• Contact by email	☐ Yes	☐ No
• Contact by post	☐ Yes	☐ No

Signature: _____ Date: _____

TO BE COMPLETED BY THE PHARMACIST

I declare that:

- I am the pharmacist who has recruited this participant
- I have provided an explanation of the Participating Information and Consent Form to the patient
- I have obtained informed consent from the patient to participate in the Trial

Pharmacy Name:

Signature: Date:

This project is funded by the Australian Government Department of Health as part of the Sixth Community Pharmacy Agreement.