The Pharmacy Guild of Australia

HealthConsult
Better thinking. Better advice.

CONSENT FORM:
PHARMACY OWNERS

Chronic Pain MedsCheck Trial

I, _____ from _____
[print your name] *[print your pharmacy name]*

have read and understood the information set out in the Pharmacy/Pharmacist Information Statement and:

☐ NO – I do not consent to participate in the Chronic Pain MedsCheck trial

☐ YES – I consent to participate in the Chronic Pain MedsCheck trial and have also obtained consent from all relevant pharmacy staff at my location to also participate in the trial *(please provide signed declarations of each pharmacists who will be involved in the Trial at your pharmacy – see Pharmacist Consent Form)*

I have read and understood the information set out in the Pharmacy/Pharmacist Information Statement and:

- I understand that neither the Pharmacy Guild of Australia nor the independent evaluation team (HealthConsult) will be directly interacting with my customers
- I agree to accept which Group (ie. Group A or Group B) into which I am randomly allocated
- I also understand that once data is obtained from my pharmacy/trial site all information will be kept by the independent evaluation team as specified and included unless I have expressly asked not to do so.

Signature:	
Date:	
Best way to contact you?	
Pharmacy Name:	
Phone:	
Email:	

Please provide the name and signature of each pharmacist at your pharmacy from whom you have obtained informed consent to participate in the Trial (see Pharmacy/Pharmacist Information Statement).

Please email form to chronicpain.ptp@6cpa.com.au

or fax to (02) 6270 1844