The Pharmacy Guild of Australia

HealthConsult
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CONSENT FORM:
PHARMACISTS

Chronic Pain MedsCheck Trial

I can confirm that my employer has provided me with the Pharmacy/Pharmacist Trial Information Statement and I understand what my involvement in the Chronic MedsCheck Trial will be. I can confirm I am a willing Trial participant and that I will comply with the Trial protocol.

Pharmacy Name:	
Pharmacist Name 1:	
Signature:	
Date:	
Pharmacist Name 2:	
Signature:	
Date:	
Pharmacist Name 3:	
Signature:	
Date:	

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

or fax to (02) 6270 1844