VERBAL CONSENT

Full name of participant:

Full name of person taking consent:

Relationship to participant:

Date and time of seeking consent:

Duration of call:

Acknowledgement

I have read and explained the contents of the Community Pharmacy in Health Care Homes Trial Program Information Statement and Consent form – July 2020 with the participant / carer.

I have provided the participant with the opportunity to ask questions and have answered all questions from the participant / carer.

Declaration

I declare that the participant / carer has consented to receive the services provided under the Community Pharmacy in Health Care Homes Trial Program and in doing so consented to the collection, use and/or disclosure of their personal information as outlined in the Information Statement.

I declare that the participant /carer understands that de-identified data will be used to evaluate the program.

I declare that the participant / carer understands that they may be contacted by the Health Care Homes evaluators on behalf of the Department of Health to participate in a survey, interview or focus group in relation to their participation in the Community Pharmacy in Health Care Homes Trial Program. The participant/carer understands that they do not have to participate in these activities if they do not want to.

Signature of pharmacist

Date

Full Name of pharmacist