NSW TAG NSW Therapeutic Advisory Group Inc. | Advancing quality use of medicines in NSW

Medicines Access Program
Patient Consent Form

I, ____, hereby agree to treatment with
(Name of patient or agent)

_______________________________________ under the specified Medicines Access Program.
(Name of medicine)

Medicines Access Program name:	
Start date:	Stop date:

Please tick the following boxes:

☐ I have been given clear information by my doctor about the reasons for using this medicine, its known effects and possible risks.

☐ I have had an opportunity to ask questions relating to the treatment and discussed alternative treatments.

☐ My doctor has advised me of any conflicts of interest he/she has in relation to this Medicines Access Program.

I understand that:

☐ The medicine is supplied under a Medicines Access Program and that in order to provide this medicine the doctor/hospital may be required to give information about my response to this medicine to the pharmaceutical company supporting the Program.

☐ The hospital is not expected to subsidise the cost of the medicine for me at the end of the Medicines Access Program.

☐ The medicine is not currently subsidised under the Pharmaceutical Benefits Scheme (PBS) and may not be subsidised for me when the Medicines Access Program ends.

☐ If the medicine is not subsidised by the PBS for me, the cost of the medicine may be high.

☐ If the medicine is not subsidised by the PBS or included on the Hospital Formulary at the end of the Program, I may need to change to a suitable alternative medicine that is subsidised.

☐ The usual hospital medication charges will apply to all items supplied under the Medicines Access Program.

Based on the information given to me (tick box if applicable):

☐ If the Program or my treatment is terminated for safety or clinical reasons and I want to continue with this medicine, I am prepared to pay the cost of ongoing treatment, which I will obtain from my local pharmacy.

Patient signature:	Witness signature:
Patient name (please print):	Witness name (please print):
Date:	Date:

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