

## PATIENT CONSENT FORM USE OF REMDESIVIR IN HOSPITALISED PATIENTS WITH COVID-19

Remdesivir is an antiviral medicine used in the treatment of COVID-19 with provisional TGA registration in Australia. Australia's [National COVID-19 Clinical Evidence Taskforce](#) has made recommendations about when remdesivir is most likely to be effective in the treatment of COVID-19.

### PATIENT CONSENT

By signing this form, I \_\_\_\_\_ understand that:

*(write name of patient / person responsible)*

- remdesivir is provisionally registered for use in Australia for the treatment of COVID-19 and more information about its effectiveness and safety is needed before it is fully registered;
- there are no guarantees of the effectiveness of remdesivir when it is used to treat COVID-19 and I/the person I am responsible for may not experience any benefit;
- there are no guarantees of the safety of remdesivir when it is used to treat COVID-19 and even with careful precautions in place, unforeseen complications may occur;
- there is potential for drug interactions (known and unknown) with the use of remdesivir; and,
- there is a possibility of experiencing side effects with the use of remdesivir (known and unknown).

I confirm that I have had the opportunity to ask questions and I am satisfied with the explanation and the answers to my questions.

I understand that I can change my mind and withdraw my consent to being treated with remdesivir at any time.

With this knowledge, I **consent** to the use of remdesivir in the treatment of me/the person I am responsible for.

**Patient's name:** \_\_\_\_\_

**Signature of patient (or person responsible\*):** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Name & signature of witness:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

Witness is not to be a member of the treating team. In the event that an interpreter is used, the interpreter may not act as a witness to the consent process. Witness must be 18 years or older.

\*If the person responsible has signed, please provide details below:

**Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Address:** \_\_\_\_\_ **Contact Number:** \_\_\_\_\_

**Relationship to patient:** \_\_\_\_\_ **Reason for representation:** \_\_\_\_\_

### DOCTOR'S DECLARATION

I have provided to the patient/their person responsible an explanation of the use of remdesivir, its potential benefits and harms and the relevant [Patient and Family Information Leaflet](#).

I believe the information has been understood.

**Doctors name:** \_\_\_\_\_ **Signature:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

If the patient cannot converse adequately in English, please use an accredited Health Care interpreter. Do not rely on relatives or other parties for interpreting.

**Language:** \_\_\_\_\_ **Name of interpreter:** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

*Completed signed form should be kept in the patient's Health Record.*