CATAG
Council of Australian Therapeutic Advisory Groups

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)

Name of program:_____

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: _____ _____ _____
(Patient signature) (Print patient name) (Date)

Witness: _____ _____ _____
(Witness signature) (Print witness name) (Date)

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