

### Appendix 3a. Consent form for self-administration of medicines for patients

<b>Patient name</b>	
<b>Hospital number</b>	
<b>Date of birth</b>	
<b>Clinical area</b>	

Or attach patient addressograph.

- I have read and understood the [self-administration of medicines information sheet](#).
- I understand that my medicine is for my use only and I should take it as instructed. If I choose not to, I will inform a healthcare professional.
- I understand that medicines I have brought in from home will be assessed and used whilst I am in hospital if suitable.
- I understand that if I am self-administering medication, I will have complete responsibility for those medicines and should inform a member of the healthcare team if anyone (patient or visitor) takes or tries to take any of my medicine.
- I understand that if I experience a side effect, I will inform a member of the healthcare team.
- I understand that medicines that the prescriber or healthcare team do not want me to take will be removed from the locker.
- I understand and give my consent that medicines I no longer require or that are out of date, may be destroyed by pharmacy staff. If medicines are out of date, I will be given a new supply of them for use in the clinical area.
- I understand that I may withdraw my consent at any time by informing a healthcare professional.
- I understand that the decision may be taken to withdraw me from the scheme if thought necessary by a registered healthcare professional. I understand I will receive an explanation for this, should this happen.
- If I have been given a key, I understand I am responsible for the safe custody of the key or digilock code and should return these when I leave the clinical area or if I am no longer participating in the scheme.
- I wish to take part in the self-administration scheme and the information I have given is true to the best of my knowledge.

<b>Patient name or representative</b>	
<b>Signature</b>	
<b>Date</b>	
<b>Witnessed by</b>	
<b>Date</b>	