COMMUNITY PHARMACY ANTI-COAGULATION MANAGEMENT S ERVICE

PHARMACY				PHN	
Title		First name(s)		Family name	
Date of birth DD/MM/YYYY			_____/_____/_____ Day Month Year	Other names known by	
Gender	Male Female			Place of birth	
Physical address	Street				
	City/ Postcode			GP/ Practice	
Contact details	Day phone	Night phone	Cell phone	Email	
Emergency contact	Name of person to contact	Relationship	Phone number	Other contact details	

I consent to registering in the Community Pharmacy Anti-coagulation Management Service and confirm that the benefits of the service have been explained to me. I understand that following each test the pharmacist will advise me on any adjustment to my dose of warfarin. I understand I have the right to exit this service at any time, and that I may need to be referred back to the care of my GP, for example if test results become unstable.

I have read and I agree with the Health Information Privacy Statement (OVERLEAF).

	/ / Day Month Year
SIGNATURE	DATE

OR Signed by AUTHORITY*

Full name of authority	Contact phone number	Relationship
Address	Signature of authority	/ / Day Month Year
Detail the basis of authority (e.g. parent of a child under 16):		

* An authority is the legal right to sign for another person if for some reason he/she is unable to consent on his/her own behalf.

Health Information Privacy Statement

I understand that:

Information about me and my health is collected for the following purposes:

- To help me to be given good quality health care and treatment.
- To add new information to my health record and use that information to provide appropriate care.
- To share relevant health information with other health professionals directly involved in my care.

Information about me and my health is also used in the following ways:

- The Pharmacy uses my information for clinical and administrative purposes.
- The Ministry of Health uses my information to give me a Personal Health Number, to update any changes, to measure how well health services are delivered and to plan and fund future health services.
- From time to time auditors are required by law to conduct financial audits of my health service providers. In the course of such audits the auditors may review transactions and I might be contacted by an auditor to check that services have been received by me. In such cases my information is only to be used to verify claims for payment made by the pharmacy.
- From time to time a clinical audit may be conducted by a qualified health care practitioner to review the appropriateness of services provided to me.
- Health information about me may be provided for statistical or research purposes but will not be published in a way that could lead to me being identified. Any research where I am identified must first be approved by an Ethics Committee.

Access to, and correction of, my health information:

- Those holding my health information are required to protect it against loss and unauthorised access, use, modification, or disclosure.
- I have the right to access health information about me but may be required to provide proof of my identity. I do not have to give a reason for requesting that information. If I request a copy of that information I understand I may have to pay an administration fee for it.
- I may ask for health information about me to be corrected and I can expect pharmacy staff to provide me with reasonable assistance. I acknowledge that my health information may not be changed unless there is reason to. If I choose to I can have a note added to my records.
- The information about me is required to be accurate, relevant, up-to-date and complete.