Appendix A

NHS
Rotherham Doncaster
and South Humber
NHS Foundation Trust

# Self-administration of Medicines

## Consent Form

I confirm that I have explained the Self-Administration of Medicine Scheme as it operates in this service area.

I have explained to the patient their responsibility to ensure that their medicines and the key to their locker (when applicable) are held securely.

Signature………………………………………………………Date ……../……/…….

Name of Nurse, Pharmacist, or Pharmacy Technician

………………………………………..…………………………………………..

**Patient**

1 Please read this form and the Patient Information Leaflet concerning the Self-Administration Scheme.
2 If there is anything that you do not understand please ask the nurse or pharmacist.
3 If you understand the explanation and wish to participate in the scheme please sign the form below.

**I, the patient, agree:**

- To participate in the Self-Administration of Medicine Scheme.
- To inform the nurses or pharmacist on the ward if I am experiencing any difficulties in taking my medicines.
- To take my medicines only as labelled.
- To inform the nurses, pharmacist or doctor of any unwanted side effects I may be experiencing.
- That if I am given a key to my bedside medicine cabinet:
  - I am responsible for safe storage of my medicines and the key.
  - I will keep the cabinet locked at all times except when taking my medicines, or when asked to open it by a nurse, pharmacist, or doctor.
  - I will **not** open it for any other member of the hospital staff, patients, or visitors.
  - I will return the key when I leave the ward.
  - That if my own medicines are considered suitable to the use, I will agree to continue to use my own medicines whilst in the hospital.

Name: ______________________________

NHS Number: ______________________________

Date of Birth: ______________________________

Signature: ______________________________

Date: ______________________________