



HOME MEDICINES REVIEW (HMR) PATIENT INFORMATION AND CONSENT FORM

INFORMATION STATEMENT

The Home Medicines Review (HMR) service provides patients with a review of their medications by a Credentialed Pharmacist in their own home. This service aims to support the quality use of medicines and reduce medication misadventure by assisting patients to better manage and understand their medicines.

In order to receive the HMR Service you need to be a Medicare and/or Department of Veterans' Affairs (DVA) cardholder, living in a community setting, at risk of or experiencing a medication misadventure and your doctor has confirmed that there is an identifiable need for a HMR service.

Under this service, your pharmacist will:

- Assess your eligibility to receive the service and obtain informed consent from you
- Visit you in your home to conduct the interview
- Review the prescription medications, over the counter medications, vitamins or supplements that you take and talk to you about your medical conditions and any allergies you may have
- Teach you how to store and take your medicines correctly
- Send a written report stating their findings and outline recommendations to members of your healthcare team and upload a record of the service to your My Health Record (if you have one)
- If necessary, visit you in your home to conduct any follow-up service(s) and make a record of your follow up service and have this available to your healthcare team
- Collect personal and sensitive information from you to enable the pharmacist to claim a payment for delivery of this service.

The Australian Government is paying the Service Provider for the HMR Service. You will not be charged a fee by the Service Provider, however, if you do not meet the Eligibility Criteria or do not consent to your information being provided to the PPA and Department of Health and Aged Care for the purpose of claiming a funded service, the Service Provider may offer the service at your own cost. **You will still be required to pay the cost of the medicines that will be checked through this HMR service including the PBS co-payment (if applicable) when medications are dispensed.**

This program is funded by the Australian Government.

WHAT YOU NEED TO KNOW BEFORE YOU GIVE CONSENT

This consent form is to allow the pharmacist to provide your personal information to the Pharmacy Programs Administrator (PPA) and the Department to verify your eligibility to receive the HMR service and to enable the pharmacist to claim a payment for providing this service.

This process is similar to the clinic/GP practice providing your Medicare number to claim for you seeing a Health Worker or GP. Your personal information is protected by law, including the Privacy Act 1988. The Department is unlikely to disclose your personal information to overseas recipients.

Your/the patient's personal information that will be collected by the pharmacy include:

- Personal details – Name, Address, Medicare number, Date of Birth
- The names of the medicines you/the patient are taking; and
- Details about the patient's authorised representative, if applicable.

If you do not provide your consent to the collection of information for this purpose, your pharmacist will not be able to assess your eligibility for the service and you will not be able to access a funded HMR service. In this event, you may be required to pay for the cost of the service to your pharmacist.

The Department has a privacy policy which you can read at: <http://www.health.gov.au/privacy>.

The Department can be contacted by telephone on **(02) 6289 1555** or free call **1800 020 103** or by using the online enquiries form at <http://www.health.gov.au>.

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The Pharmacy Programs Administrator has a Privacy Policy you can read here: <https://www.ppaonline.com.au/privacy-policy>. The Pharmacy Programs Administrator can be contacted by telephone on **1800 951 285** or email at support@ppaonline.com.au.

SERVICE DETAILS *must be filled in by the pharmacist prior to service

Name of Pharmacist Providing Service		Date of Service	
Patient Name (Given name and family name)			

PATIENT CONSENT

Consent provided by the patient:

I acknowledge I have read or had explained to me, and understand, the contents of the HMR Service Information Statement.

By signing below, I consent to receive the HMR Service and to the collection of my personal information by the Pharmacy Programs Administrator and the Australian Government Department of Health and Aged Care to enable the pharmacy to claim a payment for delivery of that service and for program monitoring and evaluation purposes.

Patient Signature		Date of Consent	
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Consent provided by a person authorised to act on behalf of the patient:

This may be filled in by the patient / individual who has the legal authority to consent and sign on the patient's behalf (for example, a guardian, a person appointed under an enduring power of attorney or a person otherwise authorised to give this consent in your State or Territory).

If you are signing on behalf of the patient, please indicate your relationship to the patient:

- Parent or guardian of child
- Enduring Guardian, recognised by a relevant state or territory law
- Enduring Power of Attorney, recognised by a relevant state or territory law
- A person who has been nominated in writing by the patient while the patient was capable of giving consent
- A person recognised by a relevant state or territory law

By signing below, I consent to the patient receiving the HMR Service and to the collection of their personal information by the Pharmacy Programs Administrator and the Australian Government Department of Health and Aged Care to enable the pharmacy to claim a payment for delivery of that service and for program monitoring and evaluation purposes.

Authorised Person Signature		Date of Consent	
Authorised Person Name			