

## INFORMATION STATEMENT FOR PATIENTS

**This service provides you with a Dose Administration Aid (DAA) also known as a webster-pak or sachets, which puts your medicines in a well-sealed, tamper-evident device.**

The device allows your individual medicine doses to be organised according to the dose schedule your health professional has directed. This service is designed to help you to manage your medicines with the goal of improved health.

In order to receive this DAA you:

- need to be a Medicare and/or Department of Veterans' Affairs (DVA) cardholder;
- identify as Aboriginal and/or Torres Strait Islander;
- live at home in a community setting;
- have trouble managing your medicines because of things like literacy or language issues, physical disability or difficulties with memory; and
- provide consent for the you/the patient's personal information to be collected.

**You are still required to pay any costs to obtain the medicines that will be packed into the DAA.**

### VERBAL OR WRITTEN CONSENT

You/the patient must consent in writing, or if that is not possible, your pharmacist or a health professional may obtain verbal consent for personal information to be collected and shared to receive this service at no cost.

### WHAT YOU NEED TO KNOW BEFORE YOU GIVE CONSENT

Do you/the patient consent to the sharing of your personal information with the Australia Government Department of Health and the Pharmacy Programs Administrator to verify you have received an IDAA service so that the pharmacy can be paid for the service provided?

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 your authorised representative, if applicable.

This information needs to be collected by the pharmacy to safely supply your medications regardless of how your DAA is funded. This information will also be given to the patient's authorised representative (if applicable) and Aboriginal Health Service if they will be providing the medication to you/the patient.

*This program is funded by the Australian Government Department of Health as part of the Seventh Community Pharmacy Agreement.*



CONTACT THE SUPPORT CENTRE: 1800 951 285 | [support@ppaonline.com.au](mailto:support@ppaonline.com.au)

## INDIGENOUS DOSE ADMINISTRATION AIDS PATIENT INFORMATION AND CONSENT FORM

This consent is to allow the pharmacy to provide your Medicare number to the Pharmacy Programs Administrator on a weekly/monthly basis to be paid 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.

Information regarding your medicines and authorised representative will only be provided if the pharmacy is audited by the Pharmacy Programs Administrator. The Pharmacy Programs Administrator may audit a pharmacy to ensure the pharmacy is accurately recording and providing the services they have been paid for.

If you/the patient's personal information is not collected by the pharmacy, the pharmacy will not be able to provide you/the patient free of charge DAAs under the IDAA Program. In this situation, you/the patient may be required to pay the pharmacy for the cost of the DAA service.

You can find further information about how your personal information is handled on the last page of this pack.

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**INDIGENOUS DOSE ADMINISTRATION AIDS PATIENT INFORMATION AND CONSENT FORM**
**VERBAL CONSENT**
**To be completed by the person obtaining verbal consent:**

Please tick both the boxes below and complete Parts A to C below.

I have explained how the patient's personal information will be collected, used and disclosed for the DAA service under the IDAA Program by reading out the statement above.

The patient or their authorised representative has provided their verbal consent for the patient's personal information to be collected, used and disclosed in accordance with this form.

**Part A: Patient's details**

<b>Patient name</b>		<b>Date of birth</b>	
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**Part B: Details of person who provided consent**

Please indicate who provided the consent:

<input type="checkbox"/> The patient
A person authorised to act on behalf of the patient:
<input type="checkbox"/> Parent or guardian of the patient who is a child
<input type="checkbox"/> Enduring guardian
<input type="checkbox"/> A person with an enduring power of attorney in relation to the patient, recognised under a relevant state or territory law
<input type="checkbox"/> A person who has been nominated in writing by the patient while the patient was capable of giving consent
<input type="checkbox"/> A person authorised to act on the patient's behalf as recognised by other relevant laws
<b>Name of authorised representative:</b>

**Part C: Details of person who obtained the consent**

<b>Name</b>		<b>Date</b>	
<b>Organisation or employer</b>			
<b>Signature</b>			

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**INDIGENOUS DOSE ADMINISTRATION AIDS PATIENT INFORMATION AND CONSENT FORM**
**WRITTEN CONSENT**

Please complete Part A and B below.

**Part A: Patient's details**

<b>Patient name</b>		<b>Date of birth</b>	
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**Part B: Consent**

*Consent provided by the patient*

- I consent to receive the DAA service under the IDAA Program and in doing so, I consent to the collection, use and disclosure of my personal information in accordance with this IDAA consent form and privacy notice.

<b>Signature</b>		<b>Date</b>	
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*Consent provided by a person authorised to act on behalf of the patient*

If you are a person authorised to act on behalf of the patient and you are completing this consent form and privacy notice on their behalf, please sign below and indicate your relationship to the patient:

- Parent or guardian of the patient who is a child
- Enduring guardian
- A person with an enduring power of attorney in relation to the patient, recognised under 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 authorised to act on the patient's behalf as recognised by other relevant laws

<b>Signature</b>		<b>Date</b>	
<b>Print name</b>			

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## Further information

### Australian Privacy Principle 5 Notification under the Privacy Act 1988

Your personal information is protected by law, including the Privacy Act 1988.

#### The Department

The Department has an Australian Privacy Principles (APP) privacy policy which you can read at <https://www.health.gov.au/resources/publications/privacy-policy>. You can obtain a copy of the APP privacy policy by contacting the Department using the contact details below.

The APP privacy policy contains information about:

- How you may access the personal information the Department holds about you and how you can seek correction of it; and
- How you may complain about a breach of
  - o the APPs; or
  - o a registered APP code that binds the Department; and
- How the Department will deal with such a complaint.

You can contact the Department by telephone on (02) 6289 1555, free call 1800 020 103 or by using the online enquiries form at <https://www.health.gov.au/about-us/contact-us/generalenquiries>.

#### The Pharmacy Programs Administrator

The Pharmacy Programs Administrator can be contacted by telephone on 1800 951 285 or email at [support@ppaonline.com.au](mailto:support@ppaonline.com.au)

The Pharmacy Programs Administrator has a Privacy Policy you can read at: <https://www.ppaonline.com.au/privacy-policy>.

The privacy policy contains information about:

- How you may access the personal information the Pharmacy Programs Administrator holds About you and how you can seek correction of it.
- How you may complain about a breach of the Australian Privacy Principles and how complaints are dealt with.

You can obtain copies of these privacy policies by using the contact details set out above.

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