3 YEAR PATIENT CONSENT FORM

Attach this form to prescriptions for **s100 Highly Specialised Drugs**

NSW GOVERNMENT Health

IMPORTANT INFORMATION FOR PATIENTS

Community pharmacists have to charge a co-payment when they sell PBS medicines. NSW Health pays the co-payments for some Section 100 (s100) Highly Specialised Drugs, for NSW residents who are patients of NSW public hospitals or authorised community prescribers.

Each time you fill your prescription at a NSW public hospital or community pharmacy in NSW **you will need to present this completed form to the pharmacist with your prescription (including any repeats)**. If this form becomes lost, damaged, or illegible, you will need to get a new consent form from your prescriber/doctor.

PATIENT AGREEMENT

I agree to NSW Health paying the co-payment on my behalf for my medicine/s. This is in line with the *National Health Act 1953 (Cth)* and the National Health (Highly Specialised Drugs Program for Hospitals) Special Arrangement 2010. I understand that:

- the pharmacist may collect health information about me and my medicine/s
- this information will be given to NSW Health to make the co-payment
- NSW Health may also use this information to evaluate this program
- My health information will be protected in accordance with NSW privacy legislation and the NSW Health Privacy Manual for Health Information

For more information on how NSW Health manages your personal information visit www.health.nsw.gov.au/pharmaceutical/s100copay/Pages/factsheets.aspx

By signing and presenting this form, you agree that the co-payment you are charged for your medicine/s will be paid by NSW Health.

SIGNATURE OF PATIENT OR AUTHORISED REPRESENTATIVE

Printed full name:

Signature:

Date signed:

INFORMATION FOR PRESCRIBERS

By completing this form, I agree that the patient:

- is a NSW resident and patient of a NSW public hospital prescriber or authorised community prescriber
- is eligible to have their s100 Highly Specialised Drug co-payment paid by NSW Health

PRESCRIBER USE ONLY

(Optional: affix patient details sticker)

PATIENT DETAILS

Patient's full name:

Patient's address:

PRESCRIBER DETAILS

Prescriber's full name:

Prescriber number:

Hospital/practice name:

Prescriber's address and phone:

PRESCRIBER SIGNATURE

Date signed:

FOR FURTHER INFORMATION PLEASE SPEAK WITH YOUR DOCTOR OR PRESCRIBER

This patient consent form is valid for 3 years from the date of patient/authorised representative signature

For more information about the Section 100 co-payments visit www.health.nsw.gov.au/pharmaceutical/s100copay

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