INFORMATION STATEMENT

The Residential Medication Management Review (RMMR) is a service referred by a Medical Professional who confirms that there is an identifiable clinical need for the Patient to have the service, and it is provided to residents living in approved Australian Government funded Aged Care Facilities. Credentialed pharmacists visit residents in facilities to conduct a comprehensive review of the resident's medication to identify, resolve and prevent medication related problems.

In order to receive the RMMR service you need to be a Medicare and/or Department of Veterans' Affairs (DVA) cardholder, currently experiencing, or at risk of experiencing, medication misadventure, have received a referral from a Medical Professional and:

- a permanent resident of an Australian Government funded Aged Care Facility; or
- a permanent resident in a facility receiving funding under the National Aboriginal and Torres Strait Islander Flexible Aged Care program; or
- a permanent resident of an MPS facility; or
- a resident in an Australian Government-funded Transition Care Facility for more than 14 consecutive days

Under this service, your pharmacist will:

- Assess your eligibility to receive the service and obtain informed consent from you
- Review your prescription medications, over the counter medications, vitamins or supplements
- Talk to you about your medical conditions and any allergies you may have
- Send a written report stating their findings and outline recommendations to relevant members of your healthcare team
- If necessary, conduct any follow up service(s)
- Upload a record of the RMMR service to your My Health Record (if you have one)
- 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 RMMR 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, Disability and Ageing for the purpose of claiming a funded service, the Service Provider may offer the service at your own cost. The service must be delivered in alignment with the RMMR Program Rules. This consent form is to be used in accordance with Section 6.3 (Patient Consent) of the RMMR Program Rules.

You will still be required to pay the costs of the medicines that will be checked through this RMMR 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 of Health, Disability and Ageing to verify your eligibility to receive the RMMR service and to enable the pharmacist to claim a payment for providing this service.

If you choose to provide written consent, the pharmacist will require you to sign the Written Consent form on page 3. If you are unable to provide written consent, your pharmacist can obtain verbal consent from an authorised person and keep a record by filling in the Verbal Consent form on page 4. If these 2 options are not suitable then verbal consent can be given by you in front of a suitable witness on page 5. If you are unable to provide consent the pharmacist will fill out the Unable to Provide Consent form on page 6.

This process is similar to the clinic/GP practice providing your Medicare number to claim for you seeing a Health Worker or General Practitioner (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 Service Provider 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 RMMR 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.

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 Referral**	
Patient Name (Given name and family name)		**Date of Service**	
Name of Facility			

WRITTEN CONSENT

Consent provided by the patient:

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

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

Patient Signature		**Date of Consent**	

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 RMMR Service and to the collection of their personal information by the Pharmacy Programs Administrator and the Australian Government Department of Health, Disability and Ageing 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			

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

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

VERBAL CONSENT (BY AUTHORISED LEGAL REPRESENTATIVE)

In some instances where consent must be obtained from an individual who has the legal authority to do so on the patient's behalf (such as a guardian, a person appointed under an enduring power of attorney or otherwise authorised to give this consent in your State or Territory), it is acknowledged that written consent may be difficult to obtain.

In these scenarios, where provision of the RMMR service is at risk of being delayed, verbal consent may instead be obtained from the legal representative.

A patient's personal details must NOT be passed on by the Service Provider if verbal or written consent has not been obtained for this to occur.

To be completed by the person obtaining verbal consent:

☐ I have explained to the patient's authorised legal representative how the information will be used for the purpose of conducting a RMMR Service as funded by the Australian Government

☐ The patient's authorised legal representative has verbally provided consent for the Service Provider to collect and disclose the patient's personal information to the PPA, the Department, the Patient's Community Pharmacy and, if required, other Service Providers for the purpose indicated above.

Please indicate who provided the consent:

Authorised Person Name (Given name and family name)		**Date of Verbal Consent**	
Authorised Person's Address			

Please indicate the authorised person's relationship with 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

Details of person who obtained the verbal consent:

Name of person who obtained verbal consent		**Name of Service Provider**	
Signature of person who obtained verbal consent			

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

VERBAL CONSENT (BY PATIENTS LACKING PHYSICAL CAPACITY ONLY)

If the patient has a condition that prevents them from providing written consent (this condition must be documented below) and there is no other suitable option to obtain written consent from the patient, the following verbal consent option may be used, provided all fields are correctly filled out.

Please note that all fields are mandatory, incomplete/incorrect forms may result in claim cancellation.

Patient Name (Given name and family name)		**Date of Referral**	
Name of Pharmacist Providing Service		**Date of Service**	
Name of Service Provider		**Date of Consent**	
Name of Facility			
Condition preventing the patient from providing written consent			

To be completed by the facility staff member witnessing the verbal consent being obtained:

☐ I confirm that I am a staff member working at the facility where the above patient resides.

☐ I confirm the pharmacist explained the RMMR service to the patient and how the patient's information will be used, including who it will be disclosed to and why.

☐ I confirm that the patient has given consent for the service.

☐ I confirm the patient has the above listed condition that prevents them from providing written consent.

Facility Staff Member Name (Given name and family name)			
Facility Staff Member Job Title		**Date Signed**	
Facility Staff Member Signature			

To be completed by the Credentialed Pharmacist obtaining verbal consent:

☐ The facility staff member and patient are present as I complete this verbal consent from.

☐ I confirm that the patient has the above listed condition that prevents them from providing written consent.

☐ I have explained the RMMR service to the patient.

☐ I have explained to the patient how the information will be used for the purpose of conducting a RMMR Service as funded by the Australian Government.

☐ The patient has verbally provided consent for the Service Provider to collect and disclose their personal information to the PPA, the Department, their Community Pharmacy and, if required, other Service Providers for the purpose indicated above.

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

UNABLE TO OBTAIN CONSENT (FOR PATIENTS UNABLE TO PROVIDE INFORMED CONSENT)

If the patient does not have the capacity to provide their consent, and there is no other suitable person who is able to provide consent on behalf of that patient, such as a guardian or a person appointed under an enduring power of attorney, a service can still be completed, where you consider that without completing a service:

- The patient's physical or mental health or safety may be significantly and detrimentally impacted;
- The patient may be exposed to a potentially life-threatening situation; and/or
- The patient might reasonably be exposed to serious injury or illness.

Your collection, use and disclosure of the patient's information under the RMMR program will be permitted under the *Privacy Act 1988 (Cth).*

If no Patient Consent (or other authorised person consent) is available please complete this section (including tick box):

☐ I, the Credentialed Pharmacist undertaking the service, confirm that the patient does not have the capacity to provide consent for this RMMR service to be undertaken and there is no suitable person to give consent on the patient's behalf. Also in my opinion, without the service, the patient is at risk of experiencing at least one of the three scenarios listed above.

Patient Name (Given name and family name)		**Date of Referral**	
Name of Pharmacist Providing Service		**Date of Service**	
Name of Service Provider		**Date of Consent**	
Name of Facility			
Provide a brief summary of the patient's condition and the reason an RMMR is needed			
Reason the patient is unable to complete the form			
Reason no other suitable person is able to complete the form			