

ANNEXURE B:

CODEINE CARE PROGRAM  
PATIENT CONSENT PRO FORMA

**Full written consent pro forma:**

I, \_\_\_\_\_ (full names and surname of consumer), an adult male / female, identity number \_\_\_\_\_ hereby declare that I have read and understood the information relating to the Codeine Care Program and consent, freely and voluntarily, to the following:

1. The provision of my identity number to my pharmacy, which is used to create a random number for me on the system, the date and quantity of codeine purchased at the pharmacy.
2. To repeat entries at all participating pharmacies of all future codeine purchases.
3. The storage of codeine purchasing data of up to a maximum of 6 months. All information on codeine purchases older than 6 months will be deleted from my profile on the system.
4. The disclosure of previous purchases at another participating pharmacy where I want to purchase codeine.
5. Anonymised consolidated reports on codeine sales will be made available to the organisation representing pharmacists (the CPS of the PSSA) and to regulatory bodies to guide the future regulation of codeine products.

**I understand and also agree to the following:**

6. My identified information will never be provided to any person other than the pharmacies that participate.
7. The database is secure, and mechanisms are in place to ensure that there is no unauthorised access to any information stored.
8. Information regarding individual dispensing history is only provided to authorised personnel in a de-identified form (i.e. de-identified by means of the random number allocated to me, which number is called up on repeat visits by means of the provision of my identity number). I understand that not the pharmacist, neither any other person will be able to see my identity number or any personal information – only a random number and codeine purchase history will be visible, which means no person can see whose information it is and only I can, by providing my identity number, cause the call-up of the information that relates to me.
9. In the event of schedule 2 - 6 medicines the law in any event requires of the pharmacist to collect certain information, which has to be entered into a separate register.
10. Pharmacists have to ensure that medicines are used safely and that medicines are not abused or misused. Pharmacists are entitled, under these rules, to refuse to provide medicine in such circumstances and may also counsel persons under circumstances of suspected abuse or misuse.
11. I can at any stage withdraw from the participating in the database, which withdrawal notice in writing, will be provided at the same pharmacy where I have signed this consent. All my information will then be permanently erased from the Codeine Care Program.
12. The Program may, in future, be extended to other products and may carry a different name, in which event I will be informed should that be the case so as to decide whether I'd like to continue or opt out of it.

\_\_\_\_\_  
Signature  
Date: \_\_\_\_\_

\_\_\_\_\_  
Witness initials, surname and signature

**Pro forma consent included on pharmacist invoice / statement provided to patient:**

By affixing my signature to this document I state that I have been informed of the Codeine Care Program, and that I agree to participate in the program, subject to the terms and conditions thereof that has been provided to me, which includes the entry of my ID number and codeine purchases into a database that is shared by participating pharmacies.

\_\_\_\_\_  
Signature