Consent to act as an agent delivering Opioid Maintenance Treatment (OMT)

Proposed Agent to complete:

I consent to act as an agent for _____(client name).

I am (circle the appropriate option):

- A friend or family member of the client
- A staff member at Directions Health Services
- A staff member at the Therapeutic Community where the client resides

I acknowledge this will involve collecting doses of Controlled Medicines from_____(pharmacy or clinic) and delivering them to _____ (client's address)

1. I have read the information sheet for agents and the procedure for OMT dose delivery and collection.
2. I will not leave any doses of OMT unattended at any time, and I will deliver the doses on the same day they are collected from the pharmacy/clinic.
3. I will maintain appropriate social distancing, and not come into direct contact with the client who is in quarantine/self-isolation.
4. I will return any doses not collected by the intended client to the pharmacy/clinic on the same day.
5. I confirm that I understand I cannot act as an agent delivering OMT if I am subject to self-isolation or quarantine. I will contact the client and the pharmacy/clinic as soon as possible should this occur.
6. I will provide identification each time I collect OMT doses.
7. I will send paperwork to the pharmacy/clinic confirming delivery of the doses to the client on the same day.

_____ _____

Agent name Agent signature

Organisation (if relevant): _____

Today's date:

AGENT CONSENT FORM

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Pharmacist, RN or Prescriber to complete:

I confirm that I have verbal consent from _____(client name) for

_____(proposed agent name) OR Directions Health Services OR Therapeutic Community staff (circle if relevant) to act as their agent.

I have checked the agent's knowledge of the requirements and procedures associated with dose delivery, and believe they understand them.

I have confirmed the identity of the agent.

An intended schedule of dose collection has been planned and complies with instructions from the client's prescriber.

_____ _____

Health Professional Name Signature

Today's date:

Accessibility

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Interpreter

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