Consent form for the self-administration of medicines programme for patients in hospital	Addressograph, or Name: DOB: Hospital no/CHI:

I, the patient, consent to taking part in the self-administration of medicines programme and agree that:

	Tick if you agree
I have read and understood the patient information leaflet 'Self Administration of Medicines in Hospital'	☐
I have had all my questions answered fully	☐
I will only take the medicines at the times written on the medicines labels	☐
I will let the nurse know if there is an error in my medicines or if I have missed taking any, or taken too much of my medicine(s)	☐
I will let the nurse know if a doctor tells me that they have changed my medicines	☐
I will let the nurse know if I have taken a medicine labelled 'as required'. These are medicines I have been advised to take if I need them	☐
I will ensure that no other patients or visitors will have access to my medicines or medicine locker or key at any time	☐
I will return any medicine locker keys when I leave hospital.	☐

Patient's signature: **Print name:**	**Date:** ___/___/___
Witness' signature: **Print name:** **Profession:**	**Date:** ___/___/___