Pharmacy Programs Administrator

NATIONAL IMMUNISATION PROGRAM VACCINATIONS IN PHARMACY CONSENT FORM

INFORMATION STATEMENT

Under this program, the Australian Government will pay your community pharmacy to administer National Immunisation Program (NIP) vaccines at no cost to you. The program increases patient access and affordability of vaccinations to help protect our community from vaccine preventable diseases.

In order to receive the NIPVIP Service, you/the patient needs to be eligible to receive the NIP vaccine, in accordance with the applicable state or territory requirements/legislation.

Under this service, your pharmacist will:

- assess your/the patient's eligibility to receive the service
- obtain written or verbal informed consent from you to receive the service
- review your/the patient's patient history, which may include checking your immunisation history on the Australian Immunisation register (AIR)
- administer a NIP vaccine and provide appropriate aftercare and/or a referral
- report your/the patient's vaccination episode to the AIR
- collect personal and sensitive information from you to enable the pharmacy to claim a payment for delivery of this service.

No additional patient fees are permitted to be charged under the NIPVIP Program, this ensures that you/the patient receive the NIP vaccine for free.

This program is funded by the Australian Government.

WHAT YOU NEED TO KNOW BEFORE YOU GIVE CONSENT

Your pharmacist or health professional will need to obtain written or verbal consent to allow the pharmacy to claim a payment for providing the NIPVIP service. This also enables the pharmacy to provide your personal information to the Pharmacy Programs Administrator (PPA) and the Department of Health, Disability and Ageing(the department) to verify your eligibility for the NIPVIP Program.

Your personal information is protected by law, including the *Privacy Act 1988*.

Your/the patient's personal information that will be collected by the pharmacy includes:

- Personal details – Name, Address, Medicare/DVA number, Date of Birth
- Details about the vaccination/s that the pharmacy administered to you/the patient
- 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 pharmacy will not be able to assess your eligibility for the service and you will not be able to receive the NIPVIP service. In this event, you may be required to pay for the cost of the service to your pharmacy.

The Department has a privacy policy which you can read at http://www.health.gov.au/privacy. The Department can be contacted by using the online enquiries form at www.health.gov.au

The PPA has a privacy policy you can read at www.ppaonline.com.au/privacy-policy. The PPA can be contacted by telephone on **1800 951 285** or email at support@ppaonline.com.au

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SERVICE DETAILS

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

Name of Pharmacist Providing Service		**Date of Service**	
Patient Name			

WRITTEN PATIENT CONSENT

Consent provided by the patient:

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

By signing below, I consent to receive the NIPVIP Service/s and to the collection of my personal information by the Pharmacy Programs Administrator (PPA) and the Department of Health, Disability and Ageing (the department) to enable the pharmacy to claim a payment for delivery of the service/s.

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 person 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

☐ Other – Please tick applicable category below:

- ☐ 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 NIPVIP Service/s and to the collection of their personal information by the PPA and the Department to enable the pharmacy to claim a payment for delivery of the service/s.

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 Service**	
Patient Name			

VERBAL PATIENT CONSENT

To be completed by the person obtaining verbal consent:

☐ I have explained the contents of the NIPVIP Service Information Statement and how the patient's personal information will be collected, used and disclosed under the NIPVIP Program.

☐ The patient or their authorised representative has provided their verbal consent for the patient to receive the NIPVIP Service/s and for their personal information to be collected, used and disclosed in accordance with this form.

Please indicate who provided the consent:

☐ The patient

☐ A person authorised to act on behalf of the patient

Authorised Person Name	

Please indicate the authorised person's relationship with the patient:

☐ Parent or guardian of child

☐ Other – Please tick applicable category below:

- ☐ 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		**Date of Verbal Consent**	
Organisation or employer			
Signature of person who obtained verbal consent			