# Appendix Three - Medication Management - Consent for the Provision of Assistance for Medication Management (Level 3)

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| --- | --- | --- | --- |
| **Name:** |  | **Date of Birth:** |  |

|  |  |
| --- | --- |
| **Address:** |  |

|  |  |
| --- | --- |
| I give my permission for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to undertake the management of my medication in accordance with my care plan. | |
| **Signed** |  |
| **Date** |  |
| **Nominated Pharmacy** |  |

|  |  |
| --- | --- |
| **Who will order the medication?** |  |
| **Who will collect the medication?** |  |

**Consider using the CMS system**

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| --- |
| For service users who are unable to give informed consent, if there is a legal Proxy who has power to consent to treatment they may sign. if no Legal Proxy is in place the G.P must complete and put in place a section 47 certificate  I give my permission for the Service to undertake the management of medication for  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ in accordance with the care plan.  Signed Proxy \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Relationship to service user \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |