Community Pharmacist-led Anticoagulation Management Service (CPAMS)

CONSENT FORM

You have been invited to take part in a service with the objective of managing your anticoagulation medication regimen in the community pharmacy setting. Your pharmacist will provide regularly scheduled INR blood testing using finger prick samples of blood. These tests will be performed on a monitor in the pharmacy that can measure the blood thinning effect of warfarin. Your pharmacist will provide advice based on the results and can prescribe or adjust your dose of warfarin if the results indicate that this is necessary.

Taking part in this service is voluntary and you can stop at any point and return to usual care with your physician and NS laboratory services for INR testing. Your pharmacist and physician will be working collaboratively throughout the project, and all test results and dosage adjustments for your warfarin medication will be provided to your physician. When appropriate, the pharmacist and physician may exchange communication by fax, secure web-based portal, phone or email.

Participation in this service does not and should not prevent you from accessing any healthcare you or your physician deems necessary. There are no known risks in being involved in the service and you will not have to pay for it. Other than as outlined in this consent, all of your information will be kept private and confidential. Your health card number is required for the provision of all pharmacy services in Nova Scotia.

I, _____ have read and I understand the Community Pharmacist-led Anticoagulation Management Service (CPAMS). I have had the opportunity to discuss this study with my physician and/or pharmacist. I am satisfied with the answers I have been given. I consent to being part of this project.

Signature: _____ Date: _____

Pharmacist Signature: _____ License #: _____