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| --- | --- |
|  | **(name of RCHD)** |
| **Consent Form for Self-storage and Self-administration of Drugs** | |

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| --- | --- | --- | --- |
| **Resident’s name** | **Sex/Age** | **HKIC no.** | **Room and/or bed no.** |
|  |  |  |  |

1. **Information of Drugs for Self-storage and Self-administration**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of Drug** | **Source** | **Purpose of Medication** | **Direction of Administration** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

1. **Confirmation by Resident and \*Guardian/Guarantor/Family Member/Relative**(\*please delete as appropriate)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| I, |  | | (resident’s name), hereby request to store and administer the | |
| above drugs by myself. I am well aware of the medical practitioner’s instructions and will administer the drugs on schedule and at advised dosage. I will also store the drugs in a secure and locked cabinet/box to prevent other residents from taking them mistakenly. | | | | |
| **Resident’s signature** | | **Name of witnessing \*guardian/guarantor/family member/relative** | | **Relationship with resident** |
|  | |  | |  |
| **Date** | | **Signature of witnessing \*guardian/guarantor/family member/relative** | | **Date** |
|  | |  | |  |

1. **Assessment by RCHD** (please tick as appropriate)

|  |  |  |  |
| --- | --- | --- | --- |
| **Assessment** | **Yes** | **No** | **Remarks** |
| The resident fully understands the medical practitioner’s instructions |  |  |  |
| The resident can comply with the medical practitioner’s instructions in administering the drugs on schedule and at advised dosage |  |  |  |
| The resident is capable of storing the drugs in a secure and locked cabinet/box |  |  |  |
| Nearby residents will not take the drugs mistakenly |  |  |  |
| The drugs listed in part (I) are suitable for self-storage and self-administration |  |  |  |

Upon an assessment, this RCHD **agree**/**disagree** to handing over the drugs listed in part (I) to the resident for self-storage and self-administration.

|  |  |  |  |
| --- | --- | --- | --- |
| \*Name of nurse/health worker |  | Name of home manager |  |
| \*Signature of nurse/health worker |  | Signature of home manager |  |
| Assessment date |  | Date |  |

1. **Remarks**

|  |
| --- |
| 1. The RCHD should monitor and assess regularly on the ability of the resident to keep and take drugs by him/herself, and update/invalidate this consent form under any following circumstances – 2. changes in the conditions of nearby residents who may take the self-administered drugs mistakenly; 3. the resident or his/her guardian/guarantor/family member/relative has requested that the drugs will no longer be stored or administered by the resident; 4. the resident’s cognitive or drug-handling ability has deteriorated; or 5. changes in the types of the drugs in part (I). 6. The RCHD is required to complete the drug delivery record, which should be signed by the resident and his/her guardian/guarantor/family member/relative for confirmation. |