香港中文大學醫院
CUHK
Medical Centre

Please affix label here

CONSENT TO ADMINISTRATION OF PATIENT OWN MEDICATIONS

Please ☑ as appropriate below

Drug Allergy(ies): ☐ NKDA ☐ Allergic to: _____

Adverse Drug Reaction(s): _____

Alert(s): _____

The Patient is named in the top right-hand corner of this Form.

The person(s) signing this Form is/are:
- ☐ the Patient.
- ☐ the Patient's Parent/Guardian (Patient who is under 18), Legal Guardian or appropriate Responsible Party.

Name in Block Letters (same as in ID): _____

Relationship: _____ Identification Document No.: _____

By signing below, I hereby confirm that I have read, and I understand and accept for myself/ on behalf of the Patient, all the terms set out in this consent form as regards my/ the Patient's own medications listed below as prescribed by my/the Patient's attending doctor and brought to CUHK Medical Centre by me/ the Patient ("**Patient Own Medications**"):

Name(s) of Patient Own Medications:

Please ☑ as appropriate below.

1. I acknowledge that I have given consent on behalf of myself/ the Patient to CUHK Medical Centre to verify and deal with the Patient Own Medications for the purposes of identifying them, assessing their suitability for re-labelling, (if applicable) re-labelling and administering them to me/ the Patient, and (if applicable) keep them until discharge by CUHK Medical Centre.
2. ☐ **Administration of identified and re-labelled Patient Own Medications**:
   I acknowledge that I understand CUHK Medical Centre has identified and re-labelled the Patient Own Medications. I further acknowledge that I understand all the risks associated with the administration of such Patient Own Medications as explained to me by my/ the Patient's attending doctor. I hereby agree and accept/ agree and accept on behalf of the Patient all the risks, responsibilities, and consequences, including but not limited to impact on my/the Patient's health condition, that may arise from the administration of such Patient Own Medications to me/ the Patient. I warrant/ warrant on behalf of the Patient not to bring any claim (in whatever form) against CUHK Medical Centre Limited, its staff members and/or my/ the Patient's attending doctor for any injury, damage, loss, costs, or expenses arising directly or indirectly from the administration of such Patient own Medications to me/ the Patient.

   ☐ **Self-Administration of Patient Own Medications that cannot be identified or re-labelled**:
   I acknowledge that I understand CUHK Medical Centre is unable to identify the Patient Own Medications or the Patient Own Medications are not eligible for re-labelling. I further acknowledge that I understand all the risks associated with self-administration by me/ the Patient of such Patient Own Medications as explained to me by my/ the Patient's attending doctor. I hereby agree and accept/ agree and accept on behalf of the Patient all the risks, responsibilities, and consequences, including but not limited to impact on my/the Patient's health condition, that may arise from self-administration of such Patient Own Medications by me/ the Patient. I warrant / warrant on behalf of the Patient not to bring any claim (in whatever form) against CUHK Medical Centre Limited, its staff members and/or my/ the Patient's attending doctor for any injury, damage, loss, costs, or expenses arising directly or indirectly from self-administration of such Patient Own Medications by me/ the Patient.
3. I have had the opportunity to ask questions and all of my questions were answered to my satisfaction.

Signature of Patient	Signature of Patient's Parent/Guardian (Patient is under 18), Legal Guardian, or appropriate Responsible Party	Date (dd-mm-yyyy)
Witness' Signature	Witness' Name (and Staff Rank, if applicable)	Date (dd-mm-yyyy)
Attending Doctor's Signature	Attending Doctor's Name	Date (dd-mm-yyyy)

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