XXXXXXXXXXXX
Thrombosis Prevention and Treatment Program (TP^2)
CONSENT

New York State now allows for Pharmacists to manage patients on anticoagulation in an anticoagulation clinic independently. Although Dr. XXXXXXXX PharmD may have seen you in the Coumadin Clinic before, this has always been under the direct supervision of the Thrombosis Program. We will now be able to have Dr. XXXXXXXX manage your anticoagulation as an independent practitioner, under a collaborative practice agreement, in Thrombosis Prevention and Treatment Program (TP^2). We have incorporated this collaboration as part of the Coumadin Clinic.

Patient Consent:

I have been told that XXXXXXXX, PharmD will be working with my doctor to provide the most appropriate way to manage my anticoagulation. I understand that Dr. XXXXXXXX has undergone specific training and has advanced knowledge in managing patients' anticoagulation medication. I also understand that by consenting to have Dr. XXXXXXXX provide this anticoagulation medication management , she will be regularly communicating directly with the head of the Coumadin Clinic, XXXXXXX MD. As part of this medication management, as is true for any care provider, Dr. XXXXXXXX may need to obtain my complete medical history, may provide education or teaching to explain the purpose or proper use medication treatment, may perform assessments, may order certain tests and she may adjust my medicine doses to provide most appropriate medication therapy to treat my condition.

I give my permission to Dr. XXXXXXXX to perform these activities. I understand that I am not in any way obligated to have my medication managed by Dr. XXXXXXXX through the Thrombosis Prevention and Treatment Program and if I withdraw my consent, she will no longer provide my medication management. Withdrawing my consent to participate as a patient of Dr. XXXXXXXX will not prevent me from obtaining my medical care and treatment from XXXXX.

Patient name: _____

Patient signature: _____ Date: _____

Signed by Dr. XXXXX XXXXXXXX, PharmD _____ Date_____