PATIENT CONSENT TO COLLABORATIVE DRUG THERAPY MANAGEMENT (CDTM)

I have discussed Collaborative Drug Therapy Management (CDTM) with my physician. I understand that through CDTM, a Clinical Pharmacist who has special training and who is certified by New York State will work closely with me and my physician. The clinical pharmacist will meet with me to review and adjust my medicines as needed. The clinical pharmacist may order tests for monitoring to help me manage my medicines better.

I understand that there is a written agreement between the clinical pharmacist and my physician that describes what clinical services the pharmacist may perform.
I understand that my participation in CDTM is voluntary and that I may choose not to participate without affecting my ability to see my doctor as I normally do.

I understand that CDTM will not be used without my written agreement to participate, but that if I do agree to participate, it will be noted in my medical record.
I understand that I or my representative may choose to stop participating in CDTM at any time. If I decide to stop participating, it will be noted in my medical record.

I understand that if I do participate, the existence of the written agreement on CDTM and my consent to such management will be shared with my primary care physician and healthcare providers at the hospital.

My signature below means that I agree to participate in the Collaborative Drug Therapy Management program at the outpatient clinics within SUNY Downstate Health Sciences University.

PATIENT: I agree to participate in Collaborative Drug Therapy Management

Patient's Name (Print)	Signature	Date	Time

WITNESS: I witnessed the patient sign this waiver.

Witness's Name (Print)	Signature	Date	Time

INTERPRETER: I have interpreted accurately and truthfully to the best of my ability.

Interpreter's Name (Print)	Signature	Date	Time