

Patient Consent Form

Use of molnupiravir (Lagevrio®) in the treatment of COVID-19 in adults

Molnupiravir (Lagevrio™) has provisional TGA registration in Australia and is used in the treatment of COVID-19. The [National COVID-19 Clinical Evidence Taskforce](#) has made recommendations about when molnupiravir is most likely to be effective in the treatment of COVID-19.

Important information to note

- Molnupiravir is provisionally registered for use in Australia to treat COVID-19. More information about its effectiveness and safety is needed before it is fully registered.
- There are no guarantees of the effectiveness of molnupiravir when it is used to treat COVID-19 and it is possible no benefit may be experienced from this medicine.
- There are no guarantees of the safety of molnupiravir when it is used to treat COVID-19 and even with careful precautions in place, unforeseen complications may occur.
- There is potential for drug interactions (known and unknown) with the use of molnupiravir.
- There is a possibility of experiencing side effects with the use of molnupiravir.

Patient's details

Patient's first and last name	
MRN	
Date of birth	

Please indicate how consent has been obtained (tick box)

Written consent	<input type="checkbox"/>
Verbal consent	<input type="checkbox"/>

I confirm that I have been able to ask questions and I am satisfied with the explanation and the answers to my questions. I understand I can change my mind and withdraw my consent to being treated with molnupiravir at any time. With this knowledge, I **consent** to the use of molnupiravir in the treatment of COVID-19 in me/the person I am responsible for:

Signature of patient (or person responsible*): _____ **Date:** _____
Leave above blank if verbal consent is obtained

Name of person providing consent (if not patient): _____
Relationship to patient: _____ **Contact telephone number:** _____

Doctor's Declaration

I have provided to the patient/their person responsible an explanation of the use of molnupiravir, its potential benefits and harms. I believe the information has been understood. *Please print & sign this form and file with the patients' Health Record.*

Doctor's name & designation _____
Signature: _____ **Date:** _____

If the patient cannot converse adequately in English, please use an accredited healthcare interpreter. Do not rely on relatives or other parties for interpreting.

Language: _____ **Name of interpreter & ID #:** _____
Signature: _____ **Date:** _____

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