CONSENT FORMS
(PHARMACY OWNERS & PHARMACIST)

Project ID: 34563
Project title: Quality family planning services in community pharmacy: expanding pharmacists’ scope of practice (The ALLIANCE Trial)

Chief Investigator: Professor Danielle Mazza
Department of General Practice

Project Manager: Dr Anisa Assifi
Department of General Practice
Email: Alliance.trial@monash.edu

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[Survey intro in REDCap is the Explanatory Statement]

**Name of pharmacy**

**Postcode**

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**Do you confirm that [pharm_name] meets the trial requirements as outlined in the Explanatory Statement?**

1) Located in a metropolitan/regional/rural area in NSW, NT or Vic
2) QCPP accredited
3) Private consultation room on premises
4) Employs at least one 0.8FTE+ pharmacist(s) willing to participate
5) The pharmacy owner consents to the pharmacy participating

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**Please select the consent form you wish to complete**

1 Consent form for individual pharmacists intending to participate in the ALLIANCE trial only
2 Consent form for pharmacy owners, to approve participation of a pharmacy practice in the ALLIANCE trial only

**[The 2 consent forms (pharmacy practices and individual pharmacists) will be accessed via the same link and branching logic will direct to the appropriate form in REDCAP]**

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I have been asked to take part in the Monash University research project specified above. I have read and understood the Explanatory Statement and I hereby give my consent to participate in this project.

**CONSENT FORM FOR PHARMACY OWNERS**

<table>
<thead>
<tr>
<th>As the owner of [pharm_name] [pharm_postcode] I consent to:</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmacist employees participating in all aspects of the ALLIANCE Trial and undertaking research-related tasks including but not limited to those outlined in the Explanatory Statement (as discussed with the ALLIANCE Project Manager) during usual work hours</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>The implementation of ALLIANCE Standard Operating Procedures in the pharmacy for the purposes of the trial, such as participant recruitment + billing procedures and the display of ALLIANCE patient resources and promotional materials</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Liaising with the ALLIANCE project team and receiving correspondence via email and phone</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>
CONSENT FORM FOR INDIVIDUAL PHARMACISTS

<table>
<thead>
<tr>
<th>As pharmacist employed by {pharm_name} {pharm_postcode}, I consent to:</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participating in all aspects of the ALLIANCE trial and implementing trial activities including but not limited to tasks outlined in the Explanatory Statement (as discussed with the ALLIANCE Project Manager)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Liaising with the ALLIANCE project team regarding any aspect of my participation and receiving correspondence via email and phone</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Undertaking research tasks during usual work hours, although I acknowledge that some tasks may need to be undertaken outside of usual work hours (e.g. educational module, questionnaires, etc.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>To take part in an interview towards the end of the trial (if randomly selected)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

I acknowledge the following:

a) Taking part in this study is entirely my choice. I am free to withdraw the pharmacy from the project at any time without explanation and there will be no negative consequences associated with refusal or withdrawal from participation.

b) I may be invited to participate in an in-depth audio-recorded interview about my experiences in this study. *(I acknowledge that my participation in the interview is voluntary - I will be given detailed information about the study and the fullest opportunity to make an informed decision about whether to participate or decline the invitation without any negative consequences to me).*

c) This project is for the purpose of research and not for profit.

d) All information about me and/or the pharmacy listed above that is gathered due to my participation in this project will be collected, analysed and kept for the purpose of this project.

e) That research data collected for the study may be published or may be provided to other researchers in a form that does not identify me in any way. The researchers have agreed not to reveal my identity and personal details.

f) I am required to alert the ALLIANCE project team (and authorities, if applicable) if serious events associated with my pharmacy’s participation in the ALLIANCE Trial occur.

Name of pharmacy owner *(if different from above)*

Signature ____________________________ Date __________

[REDCap message]

Thank you for signing the consent form to participate in the ALLIANCE trial. If you do not hear from us within 7 days, please feel free to contact the ALLIANCE team at ALLIANCE.trial@monash.edu.

Have a nice day!
CONSENT FORM
(CONSUMERS)

Project ID: 34563
Project title: Quality family planning services in community pharmacy: expanding pharmacists’ scope of practice
(The ALLIANCE Trial)

Chief Investigator:  
Professor Danielle Mazza  
Department of General Practice

Project Manager:  
Dr Anisa Assifi  
Department of General Practice  
Email: alliance.trial@monash.edu

I have been asked to take part in the Monash University research project specified above. I have read and understood the Explanatory Statement and I hereby give my consent to participate in this project.

I acknowledge the following:

a) Taking part in this study is entirely my choice. I can refuse to take part or change my mind at any time and there will be no negative consequences.
b) I may be invited to participate in an in-depth audio recorded interview about my experiences in this study, in two months’ time.
c) This project is for the purpose of research and not for profit.
d) All information about me that is gathered due to my participation in this project will be collected, analysed and kept for the purpose of this project.
e) Research data collected for the study may be published or may be provided to other researchers in a form that does not identify me in any way.

I consent to the following:

- Taking part in the ALLIANCE trial
- Completing the surveys as requested by the research team
- Receiving reminders to complete surveys via text, email and/or phone call
- My de-identified data collected in this trial may be used for future research projects related to this trial, where ethics approval has been granted.
- To take part in an interview (if randomly selected)
- Being contacted by the researchers about data related to me and my participation when it is absolutely necessary (e.g. if data or forms are missing)

☐ YES, I consent

Name of participant: __________________________

Phone number: __________________________  Email address: __________________________

Preferred contact method (please circle):  
Call  Text  Email

Preferred day (please circle):  
Mon  Tues  Wed  Thurs  Fri  Sat  Sun