INITIAL PATIENT REGISTRATION INTERVIEW FORM

Patient Details

Patient Medicare/DVA number:

Patient Date of Birth:

Patient Gender:
- ☐ Male ☐ Female
- ☐ Intersex or indeterminate ☐ Other

Where is the Patient currently living?
- ☐ Private residence
- ☐ Independent living unit within a retirement village
- ☐ Supported accommodation or supported living
- ☐ Institutional setting, including Aged Care and psychiatric/mental health community care facilities
- ☐ Other

Patient residential postcode:

Is English the primary language spoken at home? ☐ Yes ☐ No

Does the Patient identify as Aboriginal or Torres Strait Islander? ☐ Yes ☐ No

Does the Patient have a government-issued concession card? ☐ Yes ☐ No

Medication Details

Number of prescription medicines Patient is using:

Number of non-prescription medicines Patient is using:

What is Patient's average MedsIndex score?

Does the Patient have a disability that makes them eligible for a DAA?
- ☐ Physical disability
- ☐ Cognitive disability
- ☐ Physical and cognitive disability
- ☐ No disability
- ☐ Not stated/inadequately described

Does the Patient have a history of non-adherence? ☐ Yes ☐ No

Is the Patient experiencing difficulties with medication management? ☐ Yes ☐ No

In the last six months, did the Patient go to the GP or hospital because of problems with their medicines? ☐ Yes ☐ No

Was the Patient using a DAA prior to this visit? ☐ Yes ☐ No

What health condition is the consumer taking medications for? *(can select more than one)*

- ☐ CVD (including anticoagulants)
- ☐ Osteoporosis
- ☐ Pain
- ☐ Epilepsy
- ☐ Parkinson's Disease
- ☐ Alimentary tract
- ☐ Dementia
- ☐ Diabetes
- ☐ Arthritis
- ☐ Mental Health issue
- ☐ Respiratory disorders
- ☐ Other (please specify):

Does the Patient have support with managing medicines?

- ☐ Minimal (e.g. living alone)
- ☐ Occasional assistance (e.g. living alone with periodic help)
- ☐ Routine assistance (e.g. regular carer)
- ☐ Complete assistance (assistance with preparing and taking medicines)

Referral and Initial Contact

What is the referral source for the DAA?

- ☐ From HMR Management Plan MedsCheck review
- ☐ GP Referral (not from GP participating in Health Care Home pilot)
- ☐ GP Referral (from GP participating in Health Care Homes pilot)
- ☐ Self-referral
- ☐ Pharmacy
- ☐ Not stated/inadequately described

What was the date the referral/plan was made?

Date of initial contact:

DAA Details

Number of DAAs packed per week: [ ]

Frequency of collection:
- ☐ Weekly
- ☐ Fortnightly
- ☐ Monthly
- ☐ Other (please specify):

How will the Patient mainly obtain the DAA?
- ☐ Collected from Pharmacy
- ☐ Home delivered
- ☐ Other (please specify):

Type of DAA packed by the Pharmacy:
- ☐ Compartmentalised boxes
- ☐ Blister packs
- ☐ Bubble packs
- ☐ Sachet systems

Patient Consent

(as per Patient Information and Consent form)

Signed written consent for service provision ☐ Yes ☐ No

Signed written Patient consent for provision of evaluation data ☐ Yes ☐ No

Please ensure that a Patient Medication Profile is also prepared to submit with this claim.

This program is funded by the Australian Government Department of Health as part of the Sixth Community Pharmacy Agreement.

CONTACT THE SUPPORT CENTRE: 1800 951 285 | support@ppaonline.com.au