Dose Administration

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

Does the patient have a Government issued concession card?

☐ Yes ☐ No

Number of prescription medicines patient is using

Number of non-prescription medicines patient is using

Does the patient have a history of non-adherence?

☐ Yes ☐ No

Is the patient experiencing difficulties with medication management?

☐ Yes ☐ No

Does the patient have a disability that makes them eligible for a DAA?

☐ Physical disability
☐ Cognitive disability
☐ Physical and cognitive disability
☐ No
☐ Not stated/inadequately described

What is the patient's average MedsIndex score?

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 patient taking medications for? *(can select more than one)*

- ☐ CVD (including anticoagulants)
- ☐ Diabetes
- ☐ Osteoporosis
- ☐ Arthritis
- ☐ Pain
- ☐ Mental Health issue
- ☐ Epilepsy
- ☐ Parkinson's Disease
- ☐ Dementia
- ☐ Respiratory disorders
- ☐ Alimentary tract
- ☐ 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 preparation and taking of medicines)

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

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

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 Homes 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

How will the patient mainly obtain the DAA?

- ☐ Collected from Pharmacy
- ☐ Home Delivered
- ☐ Other

Type of DAA packed by the pharmacy

- ☐ Compartmentalised boxes
- ☐ Blister packs
- ☐ Bubble packs
- ☐ Sachet systems

Patient Consent

Signed Written consent for service provision
(as per Patient Information and Consent form)
☐ Yes ☐ No

Signed Written patient consent for provision of evaluation data
(as per Patient Information and Consent form)
☐ Yes ☐ No

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