Patient Registration Form

First Name .....

Last Name .....

Home Phone .....

Work Phone .....

Address .....

Suburb .....

City .....

Gender ..... Male / Female ..... Date of Birth ..... / / .....

Chronic conditions

☐ Asthma ☐ Hypertension ☐ Cholesterol

☐ Diabetes – Type I ☐ Diabetes – Type II ☐ Current / Ex-smoker

Mobile number .....

Email address .....

NHI Number .....

Ethnicity .....

General Practitioner .....

☐ Email (Tick if you want to receive email reminders)

☐ Text message (Tick if you want to receive text message reminders)

Complete this section with your pharmacist

Criteria for Provision of Medicine Use Review

Medicines check

Confirm that as a patient you:

☐ Live independently in the community and have one or more chronic conditions

Indicate which of the following criteria apply:

☐ Takes 3 or more medicines or 12+ doses of medicines per day

☐ Has multiple prescribers

☐ Has had a recent admission to hospital e.g. within last 4 weeks

☐ Takes or is about to commence taking a medicine with a high risk of adverse effects

☐ Has a particular medicine related problem, e.g. adverse reaction, non-adherence

☐ Experiences or is at risk of experiencing sub-optimal response to pharmacotherapy

☐ Has literacy/language difficulties, dexterity problems, impaired sight, or cognitive deficiencies that impact on ability to manage medicines

☐ Takes or is about to commence taking a narrow therapeutic index medicine and/or one requiring monitoring

☐ Taking or is about to commence taking a medicine being inappropriately used based on regional utilisation data