New client registration form

Hub$_2$ deprescribing & monitoring clinic

Title		Given Name(s)		Surname	
D.O.B.		Phone		Mobile	
Address		Suburb		Postcode	
Email					
Do you identify as:	☐ Aboriginal	☐ Torres Strait Islander	☐ Both	☐Neither	
Current Living Arrangements					
Health Care/Pension/Concession card number				Expiry	
Medicare Card number				Expiry	

Next of Kin - Name			
Phone		Relationship	
Address			

Regular GP name		Practice phone number	
Current psychologist or psychiatrist name			
Practice phone number		Letters included?	☐ Yes ☐ No

Allergies/alerts
Physical health diagnosis
Mental health diagnosis

Name of medications (current and previous)	Dose/Frequency	Duration	Date ceased

☐ Yes, I consent to the referral and for PCCS to contact my doctor for further information.

Client Name ..... Date .....

Client Signature .....

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