RAGLAN MEDICAL PATIENT ENROLMENT FORM

Fields with * are compulsory	***Anyone over age of 16 years must complete their own enrolment form***	**NHI** (*Office use only*)

Legal Name	Title	* Given Name	*Other Given Name	* Family Name
Other Name(s) (eg. maiden name)			**Preferred Name(s)**	
Birth Details		* Day / Month / Year	* Place of Birth	* Country of birth
Sex (at birth)	☐ Male ☐ Female		***Gender**	☐ Male ☐ Female ☐ Another Gender (please state)
Occupation				

Usual Residential Address	* House Number & St	* Suburb/Rural Location	* Town / City & Postcode
Postal Address (if different from above)	House Number & St Name or PO Box	Suburb/Rural Delivery	Town / City & Postcode

***Contact Details**	Work Phone	Mobile Phone	Home Phone	Email Address
* **Emergency Contact/NOK**	Name	Relationship		Mobile (or other) Phone

Community Services Card	☐ Yes	☐ No	Expiry Day / Month / Year	Card Number
High User Health Card	☐ Yes	☐ No	Expiry Day / Month / Year	Card Number

*** Ethnicity Details**

Which ethnic group(s) do you belong to?

Tick the boxes which apply to you

- ☐ 11 **New Zealand European**
- ☐ 21 **Māori**
  Iwi _____
- ☐ 31 **Samoan**
- ☐ 32 **Cook Island Māori**
- ☐ 33 **Tongan**
- ☐ 34 **Niuean**
- ☐ 42 **Chinese**
- ☐ 43 **Indian**
- ☐ **Other** (such as Dutch, Japanese, Tokelauan)

Please state

*** Smoking is an important factor influencing health**

If you are aged 15 and over, please tick the space that applies for you

- ☐ Currently smoke
- ☐ Recently quit
- ☐ Ex-smoker (over 1 year)
- ☐ Never smoked

Brief Advice: Smoking has hugely negative effects on your health. In most cases, you will experience the benefits of quitting immediately.

If you selected R**ecently quit or Ex-smoker**, please tick you understand the brief advice above? ☐ Yes ☐ No

If you currently smoke, would you like some help to quit? ☐ Yes ☐ No

* My declaration of entitlement and eligibility

I am entitled to enrol because I am residing permanently in New Zealand. *The definition of residing permanently in NZ is that you intend to be resident in New Zealand for at least 183 days in the next 12 months*	☐

I am eligible to enrol because:

a	**I am a New Zealand citizen** *(If yes, tick box and proceed to **I confirm that I can provide proof of my eligibility** below)*	☐

If you are **not a New Zealand citizen,** please tick which eligibility criteria applies to you (b–j) below:

b	I hold a resident visa or a permanent resident visa (or a residence permit if issued before December 2010)	☐
c	I am an Australian citizen or Australian permanent resident AND able to show I have been in New Zealand or intend to stay in New Zealand for at least 2 consecutive years	☐
d	I have a work visa/permit and can show that I am able to be in New Zealand for at least 2 years (previous permits included)	☐
e	I am an interim visa holder who was eligible immediately before my interim visa started	☐
f	I am a refugee or protected person OR in the process of applying for, or appealing refugee or protection status, OR a victim or suspected victim of people trafficking	☐
g	I am under 18 years and in the care and control of a parent/legal guardian/adopting parent who meets one criterion in clauses a–f above **OR** in the control of the Chief Executive of the Ministry of Social Development	☐
h	I am a NZ Aid Programme student studying in NZ and receiving Official Development Assistance funding (or their partner or child under 18 years old)	☐
i	I am participating in the Ministry of Education Foreign Language Teaching Assistantship scheme	☐
j	I am a Commonwealth Scholarship holder studying in NZ and receiving funding from a New Zealand university under the Commonwealth Scholarship and Fellowship Fund	☐

I confirm that I can provide proof of my eligibility	☐	Evidence sighted (*Office use only*)

My Agreement To The Enrolment Process

NB. Parent or Caregiver to sign if you are under 16 years

I intend to use this practice as my regular and on-going provider of general practice / GP / health care services.

I understand that by enrolling with this practice I will be included in the enrolled population of this practice's Primary Health Organisation (PHO) Midlands Regional Health Network Charitable Trust, and my name address and other identification details will be included on the Practice, PHO and National Enrolment Service Registers.

I understand that if I visit another health care provider where I am not enrolled I may be charged a higher fee.

I have been given information about the benefits and implications of enrolment and the services this practice and PHO provides along with the PHO's name and contact details.

I have read and I agree with the Use of Health Information Statement. The information I have provided on the Enrolment Form will be used to determine eligibility to receive publicly-funded services. Information may be compared with other government agencies, but only when permitted under the Privacy Act.

I understand that the Practice participates in a national survey about people's health care experience and how their overall care is managed. Taking part is voluntary and all responses will be anonymous. I can decline the survey or opt out of the survey by informing the Practice. The survey provides important information that is used to improve health services.

I agree to inform the practice of any changes in my contact details and entitlement and/or eligibility to be enrolled.

Signatory Details	* **Signature**	* **Day / Month / Year**	☐ **Self-Signing**	☐ **Authority**

An authority has the legal right to sign for another person if for some reason they are unable to consent on their own behalf.

Authority Details *(where signatory is not the enrolling person)*	**Full Name**	**Relationship**	**Contact Phone**
	Basis of authority (e.g. parent of a child under 16 years of age)		

HEALTH Information Privacy Statement

This Practice is committed to managing health information in accordance with the Health Privacy Information Code 2020. This means that we will protect the confidentiality of your health information as required by the Code and associated laws.

I understand the following:

Access to my health information
I have the right to access my health information under rules 6 and 7 of the Health Information Privacy Code 2020.

Visiting a different GP
If I visit a GP who is not my regular doctor, I will be asked for permission to share information from the visit with my regular doctor or practice.

If I have a High User Health Care or Community Services Card and I visit a GP who is not my regular doctor, the GP can make a claim for a subsidy. The practices I am enrolled with will be informed of the date of that visit. The name of the practice I visited and the reason(s) for the visit will not be disclosed without my consent.

Patient Enrolment Information
The information I have provided on the Practice Enrolment Form will be:

- Held by the practice
- Used by the Ministry of Health to give me a National Health Index (NHI) number, or update any changes
- Sent to Midlands Health Network and Ministry of Health to obtain subsidised funding on my behalf
- Used to determine eligibility to receive publicly funded services. Information may be compared with other government agencies but only when permitted under the Privacy Act.

Health Information
Members of my health team may:

- Add to my health record during any services provided to me and use that information to provide appropriate care
- Share relevant health information to other health professionals who are directly involved in my care

Audit
In the case of financial audits, my health information may be reviewed by an auditor for checking a financial claim made by the practice, but only according to the terms and conditions of section 22G of the health Act (or any subsequent applicable Act). I may be contacted by the auditor to check that services have been received. If the audit involves checking on health matters, an appropriately qualified health care practitioner will view the health records.

Health Programmes
Health data relevant to a programme in which I am enrolled (e.g., Breast Screening, Immunisations, Diabetes) may be sent to the PHO or the external health agency managing this programme e.g., the National Immunisation Register.

Other Uses of Health Information
Health information which will not include my name but may include my National Health Index Identifier (NHI) may be used by health agencies such as Te Whatu Ora (Health NZ), Ministry of Health or PHO for the following purposes, as long as it is not used or published in a way that can identify me:

- Health service planning and reporting
- Monitoring service quality
- Payment

Research
My health information may be used for health research, but only if this has been approved by an ethics committee and will not be used or published in any way than can identify me.

Except as listed above, I understand that details about my health status or services I have received will remain confidential within the medical centre unless I give specific consent for this information.

I have read and I agree with the Use of Health Information Statement**.**

Signatory Details:	***Signature**	***Date:** ***(dd/mm/yyyy)***	☐ **Self-Signing**	☐ **Authority**

An authority has the legal right to sign for another person if for some reason they are unable to consent on their own behalf.

Authority Details *(where signatory is not the enrolling person)*	**Full Name**	**Relationship**	**Contact Phone**
	Basis of authority (e.g. parent of a child under 16 years of age)		

RAGLAN MEDICAL

REQUEST TO HAVE MEDICAL RECORDS TRANSFERRED

Each person 16 years or over to complete and sign own form

I agree to Raglan Medical obtaining my medical records from my previous doctor in order to facilitate the provision of effective primary health care. I also understand that I will be removed from the previous practice's register.

GP2GP Transfer Information	
Doctor	Adrian Wilson
NZMC #	77980
EDI:	wstcsthc
Email:	admin@raglanmedical.co.nz
Fax:	07 825 0104

To: _____

Address: _____

Phone: _____ **Fax:** _____

Please transfer the medical records for the following patient to Raglan Medical

If your practice uses MyIndici, please deactivate MyIndici Accounts for all patient listed below.

Family Name	Given Name	DOB or NHI

RAGLAN MEDICAL
9 Wallis Street, PO Box 164, Raglan 3265

Signed: _____ **Date:** _____