# Patient Enrolment Form

All fields marked with * must be filled in

KELBURN NORTHLAND MEDICAL

**Office use only:**

ID/Visa checked……
Geo Code……
Notes box ……
NHI Validation ……
NES ……
Notes Request ……
NP alert ……
Initials & Date ……

NHI#: _____ Dr: ___

| | | | |
|---|---|---|---|
| Surname / Family name* | | First/Given name(s)* | |
| Date of Birth* | / / | Title (if used) | |
| Address* | | Preferred Name | |
| | | Postal Address (If different from physical address) | |
| | | | |
| Place of Birth* | | Gender | |
| Email Address | | | |
| Phone Numbers* | *(h)* | Mobile Phone* | *(cell)* |
| | *(w)* | Are you happy to receive text messages from us? * | *Please circle* Yes No |

| | | | |
|---|---|---|---|
| Ethnicity* | Which ethnic group(s) do you belong to? Please tick the space(s) that you belong to: | Smoking Status *(Please tick one)* * | ***Current Smoker*** |
| | | | ***Ex-Smoker*** |
| | | | ***Never Smoked*** |
| | ▪ NZ European/Pakeha | | |
| | ▪ Maori | Community Services Card? | (#) |
| | ▪ Samoan | | |
| | ▪ Cook Island Maori | Start / / | Expiry / / |
| | ▪ Tongan | | |
| | ▪ Chinese | High User Card? | (#) |
| | ▪ Indian | | |
| | ▪ Other e.g. Dutch, Japanese etc... (Please state) | Start / / | Expiry / / |
| | | **Please complete next page as well** | |

## Emergency Contact

| | | | |
|---|---|---|---|
| Surname* | | First Name* | |
| Day Phone* | | After Hours Phone* | |
| Address | | Relationship to you* | |
| | | | |

*Please choose**

I am eligible to enroll in Compass PHO. I choose to use this Practice as my regular and on-going provider of general practice/GP/First Level primary health care services. I am eligible and entitled to enroll because I am residing permanently in New Zealand and I am a **New Zealand Citizen OR**

Because I meet one of the criteria laid out in the Eligibility Guide, with the **corresponding letter**

☐ Tick

☐ Write

**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 **Kelburn Northland Medical** I will be included in the enrolled population of **Compass Health** 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.

Signed* _____ Date* _____

*Or Signed Authority (e.g. parent)*

_____ Date_____

*Relationship to patient* _____

CompassHealth
*Working together, towards healthy and flourishing communities*

# KELBURN MEDICAL CENTRE
# ELIGIBILITY CRITERIA FOR ENROLMENT

Please insert the relevant letter below on your enrolment form

**A.** I hold a resident visa or a permanent resident visa (or a residence permit if issued before December 2010)

**B.** 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

**C.** 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)

**D.** I am an interim visa holder who was eligible immediately before my interim visa started

**E.** 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

**F.** I am under 18 years old and in the care and control of a parent / legal guardian / adopting parent who meets one criterion in clauses a-f above

**G.** I am 18 or 19 years old and can demonstrate that, on the 15 April 2011, I was the dependant of an eligible work permit holder

**H.** I am NZ aid Programme student studying in New Zealand and receiving Official Development Assistance funding (or their partner or child under 18 years old)

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## Health Information Privacy Statement

**I understand the following:**

1. This practice works with Tū Ora Compass Health PHO, a not for profit organisation that supports the delivery of health care services across the Wellington, Porirua, Wairarapa and Kāpiti areas.
2. The information I provide when I enrol at this practice is shared with Tū Ora and the Ministry of Health to establish my eligibility for subsidised health care. When relevant to my subsidy eligibility, information may also be shared with other government agencies such as Immigration NZ and Ministry of Social Development.
3. My health information such as diagnoses, test results, prescribed medications, immunisations, investigations such as breast screening, and other clinical and administrative data may be shared with Tū Ora to enable them to:
    - Provide feedback to GPs, nurses and others in my practice
    - Plan, deliver, fund, monitor, and improve health services
    - Contact me in relation to services I have used, or may wish to use.
4. My health information may be shared with other health professionals who are involved in my care. It may also be shared with health agencies involved with publicly funded programmes, including Breast Screening, Bowel Screening, Immunisation and Diabetes.
5. An electronic "Shared Care Record" allows authorised health care providers, such as afterhours GPs and hospital clinicians', access to a summary of my health information, including laboratory test results, medical conditions, allergies, and prescribed medications. I can choose to opt out, but that will mean clinicians involved in my care will not have access to important health information.
6. If I am under 18, or have a High User Health Card, or Community Services Card, and I visit a GP who is not my regular doctor, this practice will be informed of the date of that visit. The name of the practice I visited and the reason for the visit will not be disclosed unless I give my consent.
7. When this practice is audited, I may be contacted by the auditor to check that I have received services. Ifthe audit involves viewing my health information, only an appropriately qualified health care practitioner will view my health records.
8. If approved by an Ethics Committee, health information that does not identify me may be used for health research.
9. I have the right to access my health information held by this practice and Tū Ora. I have a right to ask for it to be corrected if I think it's wrong.
10. My health information will only be held by Tū Ora as long as necessary for it to perform its necessary functions.
11. I understand that individuals and organisations that may have access to my health information are subject to the Health Information Privacy Code, and are required to keep my information secure.
    Office of the Privacy Commissioner | Health Information Privacy Code 2020
    For more information on health information collected by Tū Ora see: www.tuora.org.nz