

Patient Enrolment Form

University Health and Counselling Service
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Title: Mr Mrs Ms Miss Dr	Student ID number:		NHI: <i>(office use only)</i>	
Family name:			First name(s):	
Preferred name:			Other names known by:	
Gender:	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Gender diverse (please state)		Date of birth:	
Physical address:	Street or rural number:	Name of street:	Place of birth:	City/Town:
	Suburb:			Country:
	City/Town:	Postcode:	Community Services Card:	Card number:
	Country:		<input type="checkbox"/> YES <input type="checkbox"/> NO	Expiry date:
Postal address:			High User Health Card:	Card number:
			<input type="checkbox"/> YES <input type="checkbox"/> NO	Expiry date:
Contact Details:	Home phone:	Do you agree to receive unencrypted text messages? <input type="checkbox"/> YES <input type="checkbox"/> NO	Email:	Do you agree to receive unencrypted medical information via email? <input type="checkbox"/> YES <input type="checkbox"/> NO
	Cell phone:			
Emergency contact: <small>In case of emergency</small>	Name of person to contact	Relationship	Phone number	Other contact details

Which ethnic group do you belong to?	Transfer of records: In order to get the best care possible, I agree to the practice obtaining my records from my previous doctor. I also understand that I will be removed from their practice register.		
<input type="checkbox"/> New Zealand European			
<input type="checkbox"/> Māori	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NOT APPLICABLE
<input type="checkbox"/> Samoan	Doctor's name:		
<input type="checkbox"/> Cook Island Māori			
<input type="checkbox"/> Tongan			
<input type="checkbox"/> Niuean	Address/location:		
<input type="checkbox"/> Chinese			
<input type="checkbox"/> Indian			
Other such as Dutch, Japanese, Tokelauan. Please state:			

Please see over page for eligibility, consent and signature

Enrolment in the practice / Primary Health Organisation (PHO)

I intend to use **University Health and Counselling Service (“the Practice”)** as my regular and ongoing provider of general practice/ GP / First Level primary health care services.

I am eligible to enrol because:

- a. I am a New Zealand citizen (if yes, tick box and proceed to *I confirm that, if requested, 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 two consecutive years
- d. I have a work visa / permit and can show that I am able to be in New Zealand for at least two 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 old and in the care and control of a parent / legal guardian / adopting parent who meets one criterion in the 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, if requested, I can provide proof of my eligibility. _____

My agreement to the enrolment process

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 with the Primary Health Organisation (PHO) this practice belongs to, 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.

I **understand** the University may use non identifiable information for statistical analysis to monitor and improve service provision.

SIGNATURE

DATE

Confidential medical information form



HEALTH AND
COUNSELLING SERVICE

Family name:	First name:	Student ID:
Previous GP name and address:		Preferred name:

1. Do you have or have you had any of the following health problems? If yes, please tick ✓

Allergy (non-drug) Please specify:	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	Migraine	<input type="checkbox"/>
Anxiety/depression/mental health problem	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Heart disease	<input type="checkbox"/>	Bowel problems	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>	Hepatitis/liver disease	<input type="checkbox"/>	Disability	<input type="checkbox"/>
Other, please specify:							

2. Have you been in hospital or had surgery? If yes, please supply details:

Date	The type of illness/injury/operation undergone

3. Please provide details of any medication you are currently taking (including medication purchased over the counter) :

4. Do you have any allergies (drug and/or other)? No Yes **Please provide details:**

5. Are there any significant health problems in your family? (e.g. heart disease, diabetes, blood clots, stroke, Tuberculosis, mental health problems) If yes, please supply details:

Health problem	Relationship of person to you	Age they were diagnosed

6. Do you smoke?

Yes <input type="checkbox"/> No <input type="checkbox"/>	If Yes, How many cigarettes per day _____
Would you like help to quit?	Yes <input type="checkbox"/> No <input type="checkbox"/>

7. Do you drink alcohol?

Yes <input type="checkbox"/> No <input type="checkbox"/>
If Yes, What kind of alcohol? _____ How many drinks do you have in a sitting? _____

8. Immunisations:

Were you immunised as a child?	Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure <input type="checkbox"/>
Date of last tetanus booster	Date _____
Have you completed the Hepatitis B vaccination schedule?	Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure <input type="checkbox"/>

9. List any further vaccinations since childhood e.g. meningitis, Gardasil, travel vaccines

10. Women only:

Date of last cervical smear _____	Was it normal? Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure <input type="checkbox"/>
Over 45 years – Have you had a mammogram?	Yes <input type="checkbox"/> No <input type="checkbox"/>

Signature: _____ Date: _____

Use and confidentiality of your health information (fact sheet)

Your privacy and confidentiality will be fully respected. This fact sheet sets out why we collect your information and how that information will be used.

Purpose

We collect your health information to provide a record of care. This helps you receive quality treatment and care when you need it.

We also collect your health information to help:

- keep you and others safe
- plan and fund health services
- carry out authorised research
- train healthcare professionals
- prepare and publish statistics
- improve government services.

Confidentiality and information sharing

Your privacy and the confidentiality of your information is really important to us.

- Your health practitioner will record relevant information from your consultation in your notes.
- Your health information will be shared with others involved in your healthcare and with other agencies with your consent, or if authorised by law.
- You don't have to share your health information, however, withholding it may affect the quality of care you receive. Talk to your health practitioner if you have any concerns.
- You have the right to know where your information is kept, who has access rights, and, if the system has audit log capability, who has viewed or updated your information.
- Your information will be kept securely to prevent unauthorised access.

Information quality

We're required to keep your information accurate, up-to-date and relevant for your treatment and care.

Right to access and correct

You have the right to access and correct your health information.

- You have the right to see and request a copy of your health information. You don't have to explain why you're requesting that information, but may be required to provide proof of your identity. If you request a second copy of that information within 12 months, you may have to pay an administration fee.
- You can ask for health information about you to be corrected. Practice staff should provide you with reasonable assistance. If your healthcare provider chooses not to change that information, you can have this noted on your file.

Many practices now offer a patient portal, which allows you to view some of your practice health records online. Ask your practice if they're offering a portal so you can register.

Use of your health information

Below are some examples of how your health information is used.

- If your practice is contracted to a Primary Health Organisation (PHO), the PHO may use your information for clinical and administrative purposes including obtaining subsidised funding for you.
- Your District Health Board (DHB) uses your information to provide treatment and care, and to improve the quality of its services.
- A clinical audit may be conducted by a qualified health practitioner to review the quality of services provided to you. They may also view health records if the audit involves checking on health matters.
- When you choose to register in a health programme (eg immunisation or breast screening), relevant information may be shared with other health agencies.
- The Ministry of Health uses your demographic information to assign a unique number to you on the National Health Index (NHI). This NHI number will help identify you when you use health services.
- The Ministry of Health holds health information to measure how well health services are delivered and to plan and fund future health services. Auditors may occasionally conduct financial audits of your health practitioner. The auditors may review your records and may contact you to check that you received those services.
- Notification of births and deaths to the Births, Deaths and Marriages register may be performed electronically to streamline a person's interactions with government.

Research

Your health information may be used in research approved by an ethics committee or when it has had identifying details removed.

- Research which may directly or indirectly identify you can only be published if the researcher has previously obtained your consent and the study has received ethics approval.
- Under the law, you are not required to give consent to the use of your health information if it's for unpublished research or statistical purposes, or if it's published in a way that doesn't identify you.

Complaints

It's OK to complain if you're not happy with the way your health information is collected or used.

Talk to your healthcare provider in the first instance. If you are still unhappy with the response you can call the Office of the Privacy Commissioner toll-free on 0800 803 909, as they can investigate this further.

For further information

Visit www.legislation.govt.nz to access the Health Act 1956, Official Information Act 1982 and Privacy Act 1993

The Health Information Privacy Code 1994 is available at www.privacy.org.nz. You can also use the Privacy Commissioner's [Ask Us](http://www.privacy.org.nz) tool for privacy queries.

A copy of the Health and Disability Committee's Standard Operating procedures can be found at <http://ethics.health.govt.nz/operating-procedures>

Further detail in regard to the matters discussed in this Fact Sheet can be found on the Ministry of Health website at <http://www.health.govt.nz/your-health/services-and-support/health-care-services/sharing-your-health-information>.