Amuri Community Health Centre
Caring for our community

ENROLMENT FORM

WAITAHA PRIMARY HEALTH

Dr Sarah Ballam **NZMC:61476** *GP Enrolling with (Office use only)*	Amuri Community Health Centre Email: reception@amurihc.co.nz **Ph: 03 315 6328 Fax: 03 315 6592**	40 Wilkin Street, Rotherham, 7379	**EDI:** **amuricom**	NHI *(Office use only)*

Name	(Title)	Given Name	Other Given Name(s)	Family Name
Other Name(s) (e.g. maiden name)				
Birth Details		Day / Month / Year of Birth	Place of Birth	Country of birth
Gender	☐ Male	☐ Female	☐ Gender diverse (please state)	Occupation

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

Contact Details	Mobile Phone	Home Phone	Email Address
Next of Kin	Name	Relationship	Mobile (or other) Phone
Emergency Contact	Name	Relationship	Mobile (or other) Phone

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.*		
	☐ Yes, please request transfer of my records	☐ No transfer	☐ Not applicable
	Previous Doctor and/or Practice Name	Address / Location	

Ethnicity Details

Which ethnic group(s) do you belong to?

Tick the space or spaces which apply to you

- ☐ New Zealand European
- ☐ Maori — Iwi:
- ☐ Samoan
- ☐ Cook Island Maori
- ☐ Tongan
- ☐ Niuean
- ☐ Chinese
- ☐ Indian
- ☐ Other (such as Dutch, Japanese, Tokelauan). Please state

Patient Survey Contact Details as above ☐

Participation is voluntary & anonymous but continues to provide important information to improve health services.

Community Services Card	☐ Yes	☐ No
Day / Month / Year of Expiry		Card Number
I consent to receiving text message notifications	☐ Yes	☐ No
Smoking Status: Do you smoke?	☐ Yes	☐ No
Would you like support to stop?	☐ 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, 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 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, if requested, 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 Waitaha Primary Health (Primary Health Organisation) 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 my practice will have access to my Shared Care Records (Health One) from other health providers.

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)		

Pre-Registration Questionnaire
Amuri Community Health Centre

Welcome to the Amuri Community Health Centre. As part of registering with us we ask that you complete the following health questionnaire (one for each family member if appropriate) to enable us to provide you with optimum quality health care. This form will then be reviewed by a Rural Nurse to ensure your individual current and preventative health needs are added to your individual health record.

Please let the receptionist know if English is not your first language and you wish your information to be shared with a family member or friend, who interprets for you.

Name: _____ **DOB:** _____

Immunisations History:
(Please supply a vaccination certificate)

Last tetanus vaccination: Date:_____
Unknown □
Childhood vaccinations:
6 weeks □
3 months □
5 months □
15 month □
5 years □
11 years □
unknown □

Medications:

Are you allergic to any medications:
NO □ YES □

Please List & describe reaction:

Current regular medications:

Screening History:

Cervical Smears (women only):

Last smear (year) _____

Previous abnormal smear: YES □ NO □

Mammograms (women only aged 45-70 years):
Consented □ Declined □

Last screening (year) _____

Cholesterol (> 40 years):
Have you ever had your cholesterol checked?
YES □ NO □

If yes, was it high □ normal □ unknown □

Blood Pressure (>40 years):
Have you had your blood pressure checked?
YES □ NO □

If yes, was it high □ normal □ unknown □

Past Medical History:

Have you ever had:

YES □ NO □ Diabetes; if yes, is it controlled by diet / tablets / insulin.
YES □ NO □ Lung disease; if yes, which one; Asthma / Emphysema / Chronic Bronchitis
YES □ NO □ High blood pressure
YES □ NO □ Heart Disease; If yes please circle which ones Angina / Heart Attack / Heart Failure
YES □ NO □ Cancer
YES □ NO □ Depression or mood disorder
YES □ NO □ Thyroid problems
YES □ NO □ Operations
YES □ NO □ Other

If yes please specify:

Smoking & Alcohol

Smoking status: Never Smoked □
Ex-Smoker □
Current Smoker □
If smoker - how many per day? _____
Would like smoking cessation advice & help YES □ NO □

Do you drink alcohol? YES □ NO □
If yes-How many alcohol-free nights on average per week? _____
How many units per session? 1-2 □
3-4 □
6+ □

Family history

Has your mother, father, brother, sister suffered from heart disease, diabetes, cancer or any other serious health problems?
YES □ NO □
If yes, please specify: