Amuri Community Health Centre

ENROLMENT FORM

Amuri Community Health Centre
40 Wilkin Street
Rotherham, 7379

Ph: 03 315 6328 **Fax: 03 315 6592**	**GP2GP: Dr Graeme Scrivener** **EDI: amuricom NZMC: 7994**	Email: reception@amurihc.co.nz	NHI *(Office use only)*

Legal Name (Title)	Given Name	Other Given Name(s))	Family Name	
Other Name(s) (eg. maiden name) Please tick the name you prefer to be known as				
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
Emergency Contact	Name	Relationship	Mobile (or other) Phone

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

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
- ◯ Samoan
- ◯ Cook Island Maori
- ◯ Tongan
- ◯ Niuean
- ◯ Chinese
- ◯ Indian
- ◯ Other (such as Dutch, Japanese, Tokelauan). Please state

Patient Survey
From time to time we may contact you and ask for your feedback on your experience of care. This provides important information which we use to improve health services. Participation is voluntary and anonymous.

Patient Survey Contact Details: As provided above ☐ **(or)**

Alternative Mobile Phone

Alternative Email Address

☐ I do not wish to participate in the Patient Survey

I consent to Txt 2 Remind: 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 Amuri Community Health Centre I will be included in the enrolled population of Rural Canterbury PHO, 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 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
	Authority Details 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 speak to the receptionist 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? _____

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: