

PATIENT ENROLMENT FORM

Te Manu Aute Whare Oranga

O Manurewa Marae

81 Finlayson Avenue, PO Box 88-161, Clendon, Auckland

Phone (09) 640-0824 Fax (09) 266-0135 EDI: manuaute

TE MANU AUTE
WHARE ORANGA



					NHI*	
Title	Mr Mrs Ms Miss	First * Name(s)			Family Name*	
Preferred Name					Other Names Known By (e.g. maiden name)	
Gender*	<input type="checkbox"/> Male <input type="checkbox"/> Female		Place / Country of birth*			
Physical Address*	Street or Rapid (rural) number	Name of Street		Date of Birth* ____/____/____ Day Month Year		
	Suburb		City/Town		Community Services Card YES / NO	
	Postcode				Card Number Expiry Date	
Postal Address				Do you want to receive text reminders YES / NO		
Contact Details	Day Phone	Night Phone	Cell Phone		Email	
Emergency contact	Name of person to contact		Relationship	Phone number	Other contact details	

Which ethnic group do you belong to? * Mark the space or spaces which apply to you		Please tick if you are interested in the following services or programmes we have at Manurewa Marae			
Māori		Youth services and programmes		Support in past trauma / pain, breaking the cycle	
Iwi (tribe): Please state below:		Te Reo and/or Tikanga classes (Part-time courses)		Support with relationships	
Hapu (subtribe): Please state below:		Help with setting goals		Traditional Healing, Massage, Rongoa (Maori medicine)	
New Zealand European		Parenting classes		Would like to help at the Marae	
Pacific Island: Please state below:		Transfer of Records			
Other: Please state below:		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 <input type="checkbox"/> No <input type="checkbox"/> Not applicable <input type="checkbox"/>			

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Version Number	1.1	Form Ref	CL-PTE-F	Revision Date	1 April 16	

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Unknown		Doctor's Name: Address / Location:
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See page 2- for eligibility, consent and signature

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Enrolment in the Practice / Primary Health Organisation (PHO)

I intend to use Te Manu Aute Whare Oranga as my regular and ongoing provider of general practice / GP / First Level primary health care services.

I am entitled to enrol because I am residing permanently in New Zealand¹ and meet one of the following criteria:

a) I am a New Zealand citizen OR	Yes / No
b) I hold a resident visa or a permanent resident visa (or a residence permit if issued before December 2010)	Yes / No
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	Yes / No
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)	Yes / No
e) I am an interim visa holder who was eligible immediately before my interim visa started	Yes / No
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	Yes / No
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	Yes / No
h) 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	Yes / No
i) 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)	Yes / No
j) I am participating in the Ministry of Education Foreign Language Teaching Assistantship scheme	Yes / No
k) I am a Commonwealth Scholarship holder studying in NZ and receiving funding from a New Zealand university under the Commonwealth Scholarship and Fellowship Fund.	Yes / No

I confirm that, if requested, I can provide proof of my eligibility.

My agreement to the enrolment process

NB: Parent or caregiver to sign if you are under 16 years

I choose to enrol with this practice as my regular and on-going provider of general practice / GP / First Level primary health care services.

I understand that by enrolling with this practice I will be enrolled with the Primary Health Organisation (PHO) this practice belongs to, and my name address and other identification details will be included on both the Practice and the PHO Enrolment Register.

I understand that if I visit another 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 with the PHO, and their contact details.

I have read and I agree with the Health Information Privacy Statement (overleaf).

I agree to inform the practice of any changes in my eligibility.

	/ / Day Month Year
SIGNATURE*	DATE*

OR Signed by AUTHORITY²

Full Name of Authority	Contact Phone Number	Relationship
Address	Signature of Authority	/ / Day Month Year

¹ The definition residing in NZ is that you intend to be resident in New Zealand for at least 183 days in the next 12 months

² An authority is the legal right to sign for another person if for some reason they are unable to consent on their own behalf.

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Detail the basis of authority (e.g. parent of a child under 16):

Health Information Privacy Statement

I understand the following:

Access to my health information

I have the right to access (and have corrected) my health information under Rules 6 and 7 of the Health Information Privacy Code 1994.

Visiting another GP

If I visit another 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 Card or Community Services Card and I visit another GP who is not my regular doctor, he/she can make a claim for a subsidy, and the practice I am enrolled in 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 unless I give 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 the PHO 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, Immunisation, Diabetes) may be sent to the PHO or the external health agency managing this programme.

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 the District Health Board, 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, and
- payment

Research

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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 a way that can identify me.

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

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Enrolling with General Practice

General practice provides comprehensive primary, community-based, and continuing patient-centred health care to patients enrolled with them and others who consult. General practice services include the diagnosis, management and treatment of health conditions, continuity of health care throughout the lifespan, health promotion, prevention, screening, and referral to hospital and specialists.

Most general practice providers are affiliated to a PHO. The fund-holding role of PHOs allows an extended range of services to be provided across the collective of providers within a PHO.

Enrolling with a Primary Health Organisation (PHO)

What is a PHO?

Primary Health Organisations are the local structures for delivering and co-ordinating primary health care services. PHOs bring together doctors, nurses and other health professionals (such as Maori health workers, health promoters, dietitians, pharmacists, physiotherapists, mental health workers and midwives) in the community to serve the needs of their enrolled populations.

PHOs receive a set amount of funding from the government to ensure the provision of a range of health services, including visits to the doctor. Funding is based on the people enrolled with the PHO and their characteristics (e.g. age, gender, ethnicity). Funding also pays for services that help people stay healthy and services that reach out to groups in the community who are missing out on health services or who have poor health.

Benefits of Enrolling

Enrolling is free and voluntary. If you choose not to enrol you can still receive health services from a chosen GP / general practice / provider of First Level primary health care services. Advantages of enrolling are that your visits to the doctor will be cheaper and you will have direct access to a range of services linked to the PHO.

How do I enrol?

To enrol, you need to complete an Enrolment Form at the general practice of your choice. Parents can enrol children under 16 years of age, but children over 16 years need to sign their own form.

Q & A

What happens if I go to another General Practice?

You can go to another general practice or change to a new general practice at any time. If you are enrolled in a PHO through one general practice and visit another practice as a casual patient you will pay a higher fee for that visit. So if you have more than one general practice you should consider enrolling with the practice you visit most often.

What happens if the general practice changes to a new PHO?

If the general practice changes to a new PHO the practice will make this information available to you.

What happens if I am enrolled in a general practice but don't see them very often?

If you have not received services from your general practice in a 3 year period it is likely that the practice will contact you and ask if you wish to remain with the practice. If you are not able to be contacted or do not respond your name will be taken off the Practice and PHO Enrolment Registers. You can re-enrol with the same general practice or another general practice and the affiliated PHO at a later time.

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How do I know if I'm eligible for publicly funded health and disability services?

Talk to the practice staff, call 0800 855 151, or visit <http://www.moh.govt.nz/eligibility> and work through the Guide to Eligibility Criteria.

PATIENT WHANAU ORANGA INFORMATION

Surname: _____ First Name: _____

1. Do you have any, or have had any of the following medical problems, or is there Family History in any of the following:

MEDICAL	YOU	FAMILY	MEDICAL	YOU	FAMILY
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
High BP	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Depression/Anxiety	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma/Respiratory	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other Mental Health	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Liver Disease (incl Hep)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Eczema	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

2. Do you have any **other health, disability problems or inherited conditions**? Please list below

3. Please list any **regular medications (including herbal/homeopathic etc)** that you are currently taking

4. Have you had **any operations**? Yes No

If yes please list:

5. Are you **allergic to any medications**? Yes No

If yes please list:

6. Do you **smoke**? Yes If YES, how many cigarettes per day..... No Ex-Smoker

7. Do you **drink alcohol**? Yes No If YES, on average how much/weekwhat type?

8. Do you **take any other non prescription drugs**? (e.g. Marijuana, P) Yes No

9. **WOMEN 20+ years & sexually active**? When was your most recent Cervical Smear test? ___/___/___

Have you ever had an Abnormal Cervical Smear results? Yes No Don't Know

Have you had a Mammogram? (45+ yrs) Yes No Don't Know

10. When was your last Tetanus Booster? ___/___/___ Don't Know

11. Are your Childhood Immunisations up to date? Yes No Don't Know

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12. Are you under any Specialist Care, for any of the following? Don't Know No Yes Please tick -
 Cardiology CVD Renal Diabetes Mental Health
13. Do you have? No Yes HIV Aids Hep B Hep C MRSA Any other.....

Patient Authorisation to Release PHO Registration Details

Fax (06) 349-1983

Patient Surname: _____

Patient First Name: _____

Patient Date of Birth: _____ **Patient NHI:** _____

Patient Current Address

Patient Previous Address (if known)

I _____ authorise HealthPAC to release their

PHO registration details to 'Te Manu Aute Whare Oranga O Manurewa Marae Clinic'.

Patient Signature _____ **Date** _____

Practice Notification Details – please

Fax to: Te Manu Aute Whare Oranga

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