

Please tick the option which applies to you.	
Most often I would like to be seen a	at
Waikanae Health at the Beach 43 Te Moana Road Waikanae	
or	
Waikanae Heath Marae Lane Waikanae	



Waikanae Health & Compass PHO Patient Enrolment Form

- A separate enrolment form is required for each person including dependants
- * People aged 16 and over must complete and sign their own enrolment form

Please read carefully and answer every question clearly and in full.

Name		Next of Kin		
Title Surname	and the second s	Title Surname		
Full given name		First name		
Preferred name		Relationship to me		
Maiden previous surname		Address		
Personal Details Date of birth (dd/mm/yyyy)		Daytime phone		
Country where I was born		Afterhours phone		
· ·	Diverse (state below)	Emergency contact person		
		Title Surname		
NHI number (if known)		First name		
Home Address		Relationship to me		
		Daytime phone Afterhours		
##====================================	Postcode	Smoking (15 years of age and over)		
Home phone Work phon Mobile phone		Smoking (15 years of age and over) Smoking is an important factor Never smoked		
Personal email address		influencing health. Please tick the Ex-smoker		
Postal address (if different from above)	3 n	box which applies to you. Currently a smoker		
and the state of t	and the second s	Eligibility Declaration		
Solvensy year As a second seco	Postcode	I am eligible to enrol in Compass Health PHO. I choose to use		
Text Messaging	vo Fin	Waikanae Health as my regular and ongoing provider of of general		
I give permission for Walkanae Health to contact me by text	YesNo	practice/GP/First Level primary health care services. I am eligible and entitled to enrol because I am residing permanently in NZ and I		
Employment		am a NZ citizen or meet one of the criteria laid out in the		
Occupation	sa pengangangan pengangan pengangan pengangan pengangan pengangan pengangan pengangan pengangan pengangan peng Pengangan pengangan	eligibility guide (attached) with the corresponding letter:		
Employers address		I have read and agree to the terms in the Health Information		
Phone		Privacy Statement.		
Ethnicity (tick as many as apply to you)		I confirm that if requested I can provide proof of eligibility.		
New Zealand European	Niuean	l agree to inform the practice if there are any changes in my		
Maori lwi	Chinese	eligibility.		
Samoan Cook Island Maori	Indian Other (please state)	I understand that by enrolling with Waikanae Health, I will be enrolled with the Primary Health Organisation (PHO) this practice		
Cook Island Maori Tongan	lanier (hiease state)	belongs to and my name and address and other identification		
Community Services Card		details will be included on both the Practice & the PHO		
I have a current Community Services card	Yes No	Enrolment Register.		
Card number	Expires:	I understand that if I visit another provider where I am not		
High User Health Card		enrolled I may be charged a higher fee.		
I have a current High User Health card	Yes No	I have been given information about the benefits and implications of enrolling with the PHO and their contact details		
Card number Rower of Attorney for Personal Cares & V	Expires: Welfare	of enroling with the PHO and their contact details. I understand that the practice participates in a national survey		
Power of Attorney for Personal Cares & Welfare The person who holds legal Power of Attorney on my behalf		about people's health care experience and how their overall care		
Title Family name		is managed. Taking part is voluntary and all responses will be		
Full given name		anonymous. I can decline the survey or opt out of the survey by		
Relationship to me		informing the practice. The survey provides important information		
NB - Please provide a copy of the document p		that is used to improve health services.		
cares and welfare as it will need to be remain o		Patient Agreement		
Transfer of Medical Records (New patie	CONTROL OF STREET AND	Signature		
In order to get the best care possible, I authorise Waikanae Health to obtain all my medical records from my previous GP. I understand that		Signature Date Or		
I will be removed from their register.		Signed by Authority Date		
	t applicable	Full name		
Doctor		Relationship to patient		
Practice		Photo Identification Provided		
Address		Form of photo identification I have provided:		
		Drivers Licence Passport Other		
Phone Fax		<u> </u>		

Waikanae Health

New Patient Information Questionnaire

me:	
te of Birth:	Date:
Do you suffer from any current/long term	n medical problems? (Please include date of onset)
	7-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1
Have you had any serious medical proble	ems in the past? (Please include dates)
Surgery:	
	· · · · · · · · · · · · · · · · · · ·
,	
Other:	
What medication are you currently on?	(Please list and include over-the-counter and 'natural' medicines
,	
	· · · · · · · · · · · · · · · · · · ·
	3
Do you have any known allergies or reac	tions to particular medicines or substances?
	7.1.4.4.7.
Hove you ever made due - de-to-2	Vac. / Na
Have you ever smoked regularly?	Yes / No
If so, for how many years?	
What date did you quit?	If you currently smoke, how many per day on average?

Alcohol: What w				
	·			
	ur family members			ease or cancer before thosis and their relationshi
		· · · · · · · · · · · · · · · · · · ·		
	- Complete and the Comp			
				
	a Specialist or any			so please state the name
Are you under	a Specialist or any	other health provider f he condition being trea		so please state the name
Are you under the Specialists	a Specialist or any			so please state the name
Are you under the Specialists	a Specialist or any	he condition being trea		o please state the name
Are you under the Specialists Immunisations: Adults – Are you	a Specialist or any o	he condition being trea	ated.	
Are you under the Specialists Immunisations: Adults – Are you Children (0-16 ye	a Specialist or any of sor Provider and to up to date with you ars) — Are you up to	ne condition being trea ur Tetanus? o date with your childh	ood immunisations	Yes / No
Are you under the Specialists Immunisations: Adults – Are you Children (0-16 ye	a Specialist or any of sor Provider and to up to date with you ars) — Are you up to	he condition being trea	ood immunisations	Yes / No
Are you under the Specialists Immunisations: Adults – Are you Children (0-16 ye Women: If known, the company abnormal	a Specialist or any of sor Provider and to the solution of the	ne condition being treature. Tetanus? date with your childh smear: t required.	ood immunisations last mammogra	Yes / No Yes / No
Are you under the Specialists Immunisations: Adults – Are you Children (0-16 ye Women: If known, the o	a Specialist or any of sor Provider and to up to date with you ars) — Are you up to late of last cervical results or treatments.	ne condition being trea ur Tetanus? o date with your childh	ood immunisationslast mammogra	Yes / No Yes / No

We strongly advise that you make a Nurse appointment to discuss the above and record it, and any other information on your file with us. Once you have received our enrolment confirmation letter, please contact Reception on 04 293 6005 and ask for a New Patient Nurse appointment.



Eligibility Summary Guide

I am fully eligible and entitled to be enrolled with Waikanae Health and the PHO (Primary Health Organisation) if I am residing permanently in New Zealand (183 days out of the next 12 months) and..... Α I hold New Zealand Citizenship. I hold a resident visa or a permanent resident visa (or a residence permit if issued before В December 2010). I am an Australian citizen or Australian permanent resident AND I am able to show I have been C in New Zealand or I intend to stay in New Zealand for at least 2 consecutive years. I have a work visa or work permit and I am able to show that I am able to be in New Zealand D for at least 2 years (previous permits included). E I am an interim visa holder and I was eligible immediately before my interim visa started. I am a refugee or protected person. OR I am in the process of applying for or appealing refuge F or protection status. OR I am a victim or suspected victim of people trafficking. I am under 18 years and in the care of a parent/legal guardian/adopting parent who meets one G of the criteria in clauses $\mathbf{A} - \mathbf{F}$ (above) I am 18 or 19 years old and can demonstrate that on 15th April 2011 I was the dependant of an Н eligible work visa or work permit holder (The visa or permit must still be valid) I am a New Zealand Aid Programme student, studying in New Zealand and receiving Official Development Assistance funding (or their partner or child under 18 years old). J I am participating in the Ministry or Education Foreign Language Teaching Assistantship schem I am a Commonwealth Scholarship holder, studying in New Zealand and receiving funding from K a New Zealand University under the Commonwealth Scholarship and Fellowship Fund

Please note:

You will need to provide proof of eligibility – your Passport and other documentation to demonstrate you are eligible to or intend to stay in New Zealand for the next 2 years.

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
- share relevant health information to other health professionals who are directly involved in my care.

Shared Care Record

An electronic summary of my health information will be available to health professionals in hospitals and other settings who are directly involved in my care. If I do not want my information to be available on the Shared Care Record, I have the option to opt out, or to have specific health information excluded. For more information visit www.scr.org.nz

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 (eg: 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
- payment.

Research

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.

www.compasshealth.org.nz enquiries@compasshealth.org.nz

Wellington

Level 7, Freemason House 195-201 Willis Street, Wellington 6011 PO Box 27 380, Marion Square Wellington 6141 Wairarapa Waiata House 27-29 Lincoln Road Masterton 5810 PO Box 314 Masterton 5840

Phone: Fax: 06 370 8055 06 370 8454

INFORMATION FOR NEW PATIENTS TO THE WAIKANAE HEALTH CENTRE

If you are a new patient to the Waikanae Health Centre and live outside our practice area, please read this carefully and sign below to indicate your agreement and understanding.

Waikanae Health Centre provides a full service to all registered patients who live within the area from south of Te Waka Road, Te Horo in the north to north of Otaihanga Road, and Main Road South as far as Southwards Turnoff. This includes urgent housecalls, and access to medical services for 24hr emergencies.

We encourage patients from outside this area to register with a GP in their own locality. If you live <u>outside</u> this area, but wish to be seen as a casual patient at the Waikanae Health Centre, you may do so, but this is on the understanding that we are unable to respond to any requests for housecalls. This means that the on-call duty doctor will agree to see you if you can come to the Centre. You should also be aware that funding from the Capital and Coast DHB for projects such as COPD and Diabetes etc, will not be available to patients who live outside the geographical boundaries of the DHB, ie north of Peka Peka.

If you understand this arrangement, and still wish to register as a patient, please sign below. We would still advise you to make arrangements for any after hours service you may need with a doctor in your locality.

AGREEMENI:
/Wehave read and understand the above statement of the Waikanae Health Centre. I am aware that Waikanae Health Centre doctors do not make housecalls to my area.
Signed: Date:
Print Full Name:
Chart No: