ENROLMENT PACK

Enrolment Process

As part of the Kauri HealthCare enrolment process, we require all new patients to meet with our Health Promotions Co-ordinator to allow you to go through your notes and to ensure that we have the correct information on file for your new doctor. This appointment is 30 minutes long and you will be charged $31.00. Patients have found this consult helpful, as it highlights to the doctor what your initial concerns are as well as allowing us to document your medications (please bring your medications to this appointment).

This check will also include an introduction to Kauri HealthCare, the services available to you, a health check and a brief discussion on self-management (MyIndici). This is an electronic portal which allows you to get a copy of your test results, request repeat prescriptions, making appointments as well as giving you the opportunity to talk to your doctor about any health concerns.

Signature _____ Date _____

Please return this form along with your enrolment form and the new patient information sheet also included in this pack to admin@kaurihealthcare.nz

For Office Use Only (for staff to complete)	Date Received:
Signed enrolment form:	Signed:
Documents all attached:	

ENROLMENT PACK

Patient details: All fields ***Must*** be completed	EDI number: vaa3ifhc Doctor: NZMC:	NHI (*Office use only)*

Name	(Title)	Given Name	Other Given Name(s))	Family Name
Other Name(s) (eg. maiden name)			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
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
- ◯ Samoan
- ◯ Cook Island Maori
- ◯ Tongan
- ◯ Niuean
- ◯ Chinese
- ◯ Indian
- ◯ Other (such as Dutch, Japanese, Tokelauan). Please state

Iwi (if applicable):

Community Services Card ☐ Yes ☐ No

Day / Month / Year of Expiry | Card Number

Smoking Status:

☐ Current Smoker ☐ Never Smoked

☐ Ex-Smoker <12mths ☐ Ex-Smoker >12mths

If Current Smoker:

The best advice we can give you for your health and well-being is to quit smoking, here at Kauri Health Care we can help you on your journey to wellness, please tick if you would like to be contact for support to quit smoking.

☐ Yes I would like to be contacted

☐ No, I would not like to be contacted at this time – *you may be asked again in the future*

ENROLMENT PACK

Primary Health Services Provider Enrolment Form

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 enroll 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 Kauri Healthcare will be included in the enrolled population of Central 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 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 consent to *(Please tick if applicable)*:

☐ Import clinical records from enrolled practice ☐ Share my records on Indici SEHR
☐ Share clinical records with enrolled practice ☐ Share Health Info with other Health Providers in my care
☐ To use the provided email address to receive communication from practice (including clinical information)

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)		

ENROLMENT PACK

New Patient Information Sheet

This form is to be completed by new patients joining Kauri HealthCare. It is vitally important that we have accurate and current information to ensure best practice.

Your Practitioner will be:

Date: Surname: First & Middle: Preferred Name: Gender: Male Female	Address: Ethnicity: Residential Status: NHI: CSC number: Pharmacy:
1. Phone: Day	Mobile Phone Number: Email:
Date Of Birth:	Place Of Birth:
With whom do you live?	Occupation: Employer: Phone:

Marital Status	Single	Married	De Facto Spouse
	Separated	Divorced	Widowed

Next of Kin Details:

Name: Relationship:

Phone Home:

Address: Work:

Mobile:

Please bring in Plunket books for all children aged 11 or under.

Names of Dependant Children	Date of Birth	Vaccination History

This form is to be completed by new patients joining Kauri HealthCare.

Kauri HealthCare

ENROLMENT PACK

Medical History	**You**	**Family member**
	Yes/No	Yes/No
Have you or any member of your family ever had asthma, used an inhaler medication or been troubled by shortness of breath?		
Do you or any member of your family have diabetes or raised blood sugar levels?		
Have you or any member of your family ever had epilepsy, experienced fits, seizures, convulsions, fainting or blackouts?		
Have you or any member of your family ever had heart disease, heart murmur or irregular heartbeat?		
Do you experience chest pain or angina?		
Have you or any member of your family ever had or been told that you have high blood pressure?		
Have you ever had injuries that have led you to see a doctor, physiotherapist or chiropractor?		
Have you or any member of your family ever been diagnosed with hepatitis, HIV, or Aids?		
In the past two years, have you suffered from migraines or persistent headaches?		
Have you ever consulted a psychiatrist or psychologist?		
Have you or any member of your family ever suffered from mental illness, depression, anxiety or stress?		
Have you or any member of your family ever been diagnosed with any form of cancer, including skin cancer?		
Have you or any member of your family ever suffered from arthritis or any bone or joint problems?		
Are you currently receiving treatment for any health conditions?		
Do you or should you wear glasses or contact lenses?		
Do you have trouble hearing?		
Have you had any operations?		
Have you been in hospital for any other illness?		
Have you ever seen a specialist about any other problems?		
Have you ever had any specialist's tests: i.e. barium meal, gastroscope, cardiograph?		
Do you have any long-term illness or disability: i.e. raised BP, skin complaint, diabetes, asthma?		
If you answered Yes to any of the questions above, please provide the details here:		

Kauri HealthCare

ENROLMENT PACK

Please list any current medications you are taking:

Are you Allergic to any medications / food? **Yes** **No** If Yes please give details:

Immunisations History i.e. Tetanus, Hepatitis

Lifestyle

Do you smoke?	Yes/No number per day:
Have you ever smoked?	Yes/No gave up in
How much alcohol do you drink?	Per Day: Per Week:
How often do you engage in regular exercise? (eg active gardening, brisk walking, dancing – for at least 30 minutes)	Times per week:

Women

Number of Children	Year born:
Pregnancy history (Caesar, miscarriage etc)	
Form of contraception (if relevant)	
Date of last cervical smear	Date:
Date of last mammogram	Date:

ENROLMENT PACK

REQUEST TO TRANSFER MEDICAL RECORDS

Patient Name:……

Date of Birth:…….. NHI #:……

Patient Name:……

Date of Birth:…….. NHI #:……

Patient Name:……

Date of Birth:…….. NHI #:……

Request that my medical records be transferred from:

Previous Medical Centre:……..

Address:……

Fax:…… OR

Email:……..

Signature:……..

Date:……

All patients over the age of 16yrs must sign their own consent to transfer medical files

Kauri Healthcare
619 Featherston St
PALMERSTON NORTH **EDI: vaa3ifhc**

Fax 063581836
Email admin@kaurihealthcare.nz