National Hauora Coalition

Enrolment Form

Please see our website for fees and more information

Everyone aged 16 and over must complete and sign their own enrolment form.	**NHI** *(Office use only)*
Title:	
Family Name:	
First Name:	
Middle Name:	
Preferred Name:	
Other/ Maiden Name:	
Occupation:	
Employer Details:	
Marital Status:	
Sex (at birth) ☐ Male ☐ Female	**Gender** you would like to be identified as ☐ Male ☐ Female ☐ Gender Diverse

Ethnicity:

Which ethnic group do you belong to? *Tick the box or boxes which apply to you.*

☐ **Māori Iwi**____________________

☐ **Samoan** ☐ **Tongan** ☐ **Cook Island Māori** ☐ **Niuean**

☐ **New Zealand European** ☐ **Australian** ☐ **South African**

☐ **Indian** ☐ **British** ☐ **Filipino** ☐ **Chinese**

☐ **Other such as *Dutch, Japanese, Tokelauan.*** Please state:

Date of Birth:	
Country of Birth:	
Place of Birth:	

Residential Address	
Suburb/Rural Location	
Postal Address (if different from above)	
Suburb/Rural Location	
Preferred Pharmacy for prescriptions	

Mobile Phone:	
Work Phone:	
Home Phone:	
Primary Email:	
Contact Methods: Please note if you decline text, you will not receive script alerts.	☐ Cell phone ☐ Day phone ☐ Email ☐ Post ☐ Decline Text

Consent to share my records on Indici SEHR *Allow authorised healthcare professionals to view a summary of your health information when required*	☐ Consented ☐ Declined
Consent to share health information with external healthcare professionals involved in my care	☐ Consented ☐ Declined

Community Services Card	☐ yes ☐ no	Expiry date	Card Number
High User Health Card	☐ yes ☐ no	Expiry date	Card Number
Account holder	☐ Self ☐ Company ☐ Other (Please specify)		Account holder name and surname
Emergency Contact / Next of Kin	Name & Surname	Relationship	Contact Phone

Smoking is an important factor influencing health If you are 15 years or older, please tick the box that applies to you.	☐ Currently Smoking ☐ Ex-smoker Quit date:______________ ☐ Never Smoked	*Smoking has a significantly harmful impact on our health. In most cases, the benefits of quitting can be felt almost immediately.* **If you currently smoke**, would you like some free help to quit? ☐ yes ☐ no

We utilise a note taking tool called Heidi AI to capture the details of your consultation accurately and efficiently. Conversations are transcribed while they happen, meaning no recording is ever stored. Heidi is compliant with the Privacy Act 2020 and New Zealand Information Privacy Principles

☐ **Consent to Use Heidi AI** ☐ **Decline to Use Heidi AI**

National Hauora Coalition

My declaration of entitlement and eligibility

Eligibility to enrol: (tick **ONE** of the following)

a	I am a **New Zealand citizen**	☐
b	I hold a **resident visa or a permanent resident** visa (or a residence permit if issued before December 2010)	☐
c	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) Date of arrival into New Zealand: _____/_____/_____	☐
d	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	☐
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	☐
k	None of the above. Please give more details on your current situation:	☐

I confirm that, if requested, I can provide proof of my eligibility	☐	Evidence sighted (*Office use only*)

I am residing permanently in New Zealand and therefore **I am entitled to enrol** *The definition of residing permanently in NZ is that you intend to be resident in New Zealand for at least 183 days (6 months and 1 day) in the next 12 months*	☐ Yes ☐ No

All patients 16 years of age and over - Please supply a copy of your photo ID (driver licence or passport). If you were NOT born in New Zealand, please supply a copy of your passport and visa

Practice Mailbox/EDI: cammccam **NZMC:** cammc
First Name: Cambridge **Last Name:** Medical Centre

CAMBRIDGE MEDICAL CENTRE

My agreement to the enrolment process

Note: A parent or caregiver must sign if you are under 16 years old.

I intend to use this practice as my regular and on-going provider of general practice / GP / health care services.

I agree to Cambridge Medical Centre obtaining my medical records from my previous doctor.

I understand that by enrolling with Cambridge Medical Centre I will be included in the enrolled population of The Midlands Regional Health Network Charitable Trust, 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. Please refer to Cambridge Medical Centre's website.

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.

Authorisation and Consent

The main purpose for collecting this information is to assist in your care and treatment, but there are other related purposes such as assisting with the administrative aspects of your care; and monitoring the quality of patient care, treatment, add health outcomes of our patients.

You should note that:

All personal information collected during your treatment will be filed as part of a medical file and is subject to the provisions of the Health Information Privacy Code; 2020.

You have the right to access this information and to request changes to personal details.

Information may; be conveyed to other health practitioners in the interest of your treatment.

Some information collected about you will be forwarded to the Ministry of Health or it's agent and to the New Zealand Health Information Service.

Some Information may be used for statistical purposes that will not identify you.

Under the Privacy Act 2020, Cambridge Medical Centre requires your permission to collect and hold information about your participation in the services offered by these organisations.

Signatory Details	Signature	Date signed	☐ Self-Signing	☐ Authority

An authorised person has the legal right to sign on behalf of someone who is unable to give consent themselves. Parents must sign as the authority for children under 16 years of age. In all other cases, please provide supporting documentation (e.g. activated Enduring Power of Attorney or legal guardianship papers).

Authority Details (if signing on behalf)	**Full Name**	**Relationship**	**Contact Phone**

National Hauora Coalition

CAMBRIDGE MEDICAL CENTRE

REQUEST TO HAVE MEDICAL RECORDS TRANSFERRED

In order to receive the best care possible, I agree to **Cambridge Medical Centre** obtaining my medical records from my previous doctor. I also understand that I will be removed from my previous doctor's register.

Each individual must complete a separate form. **Those aged 16 and over are required to sign their own form.**

Patient details:

Full Name: ______________________________

Date of birth/NHI: ______________________________

Signed: ______________________________

(16 years and older to sign own form)

Date: ______________________________

Previous Medical Centre:

* Please note transferring your medical records is a requirement of enrolling with Cambridge Medical Centre. Your previous centre has 10 working days to transfer your records. You will be unable to make an initial appointment to see your new doctor until we receive these records. If applicable, please ensure that you have enough medication to cover the 6-week transition period.

* Please note if you are transferring from an overseas practice, we are unable to request your notes.

Previous Clinic Name: ______________________________

Email Address.: ______________________________

Our practice would prefer electronic transfers.

FIRST CONSULT BOOKING	
Patients on long term medication	1 x Advance Nurse Consult and 1 x Doctor consult
Patients without long term medications	1 x Doctor onsult

Please see our consultation charges on our website

CAMBRIDGE MEDICAL CENTRE
For GP2GP transfers, please use the following info:

Practice Mailbox/EDI: cammccam
NZMC: cammc (this is our NZMC number)
First Name: Cambridge
Last Name: Medical Centre

Ph: 07 8277184 / info@cambmedcentre.co.nz

National Hauora Coalition

CAMBRIDGE MEDICAL CENTRE

Medicines List

Patient Name: ______________________________

Patient Date of Birth: ______________________

List any long-term medical conditions & health concerns:	List any allergies and/or any adverse drug reactions and type of reaction:

List of all my medicines, inhalers, creams, drops and supplements

Medicine name (s)	Strength	Medication times & dose					Comments
		Waking	B/fast	Lunch	Dinner	Bed	

Also include inhalers, eye drops, vitamins, supplements, herbal products.