ENROLMENT FORM

Roxburgh Medical Services
65 Scotland St, ROXBURGH Phone: 03446 8200 Fax: 03446 8948

* Compulsory Fields	GP2GP: Kate Stark NP 123255 EDI: roxbrgmc	NHI *(Office use only)*

***Name**	(Title)	Given Name	Middle Name	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	SMS Y / N	Home Phone	Email Address
Employer Details	Company		Phone	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	**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	
		Smoking Status: Please circle Smoker Never Smoked Trying to give up Stopped in last 12 months Stopped more than 12 months Would you like help to quit ☐ Yes ☐ No		
		Office Use Only: **Date Received:.........................Signed:.......................................** **Notes Requested......................Signed:.......................................**		

*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 Roxburgh Medical Services Trust I will be included in the enrolled population of WellSouth Primary Health Network, 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 understand that the practice may share my health information between healthcare providers using HealthOne, a secure system for storing electronic patient records and that all information is kept confidential and checks are in place to monitor all access.
I understand that further information on HealthOne is available from the practice on request.
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
	Signature of Authority		

Authority Details	Address

/ /
Day Month Year

NAME: ____ *male/female/gender diverse (circle)*
Please fill in the following details to the best of your knowledge. This information helps us to provide better care for you.

1. **Current Medication:**

____
____
____
____

2. **Allergies:** **YES/NO**

If YES - Type of Reaction ____

Food/Drug Allergy if known ____

3. **Health History:**

Exercise ____________ times WEEK

Alcohol YES __________________ (how many Standard Drinks per week) NO ☐

4. **Immunisations:** Have you had all childhood/adolescent vaccinations **YES/NO/UNSURE**

5. **Smoking:** **SMOKER** ☐ **Ex-Smoker** **<**15 months ☐ >15 months ☐ **NEVER SMOKED** ☐

6. Would you like support from Roxburgh Medical Services to give up smoking **YES** ☐ **NO** ☐

7. **List significant Medical History (including family) past and present. Include illnesses, accidents, injuries, operations and procedures. YES** ☐ **NO** ☐

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8. I give permission for Roxburgh Medical Services to contact me by text message **YES** ☐ **NO** ☐

9. **HealthOne** (Shared Care Record View) is a secure record that stores health information including GP and hospital records, prescribed medication and test results and may be used by Clinicians to assist with my health care. I give my permission. **YES** ☐ **NO** ☐

I understand the 'Practice Policy for Notification of test results: YES ☐ **NO** ☐

Signed: ___________________________________ **Date:** _________________________

Staff initial/sign _________________