

Patient Enrolment Form

Student Health and Support

PO Box 85084, Lincoln University, Lincoln 7647
Phone 03 325 3835, Fax 03 325 3881



New Zealand's specialist land-based university

Transfer of notes: GP to GP	EDI lincuniv	MC 17117 Dr. Jackie Blunt	NHI Number (office use only)	Student ID number
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Family name:* First name:* Middle name(s):

Preferred name: Date of birth:* / /
Day Month Year

Male Female Gender diverse (Please state)

Place of birth: Country of birth (as stated on passport):

Phone number: Mobile: Home: Work:

Email address: Occupation:

Physical address:

(Street address or rapid address number required **not** a PO Box or private bag number)

Street:

Suburb:

City:

Postcode:*

Postal address: (If different from physical address)

Street/PO Box/Private bag:

Suburb:

City:

Postcode:

University address (if relevant):

Emergency contact details:

Name: Relationship: Contact number:

Which ethnic group do you belong to?

Mark the space or spaces that apply to you

- New Zealand European
- Māori Iwi
- Samoan
- Cook Island Māori
- Tongan
- Niuean
- Chinese
- Indian
- Other (such as Dutch, Japanese, Tokelauan)
Please state:

Community Services card:

Yes No Expiry date:
Number:

High user card:

Yes No Expiry date:
Number:

Smoking status:*

<input type="checkbox"/> Smoker	<input type="checkbox"/> Ex-smoker Less than 15 months ago	<input type="checkbox"/> Ex-smoker More than 15 months ago	<input type="checkbox"/> Never smoked
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If yes, would you like support to quit?

Signatory Details	Signature <input type="text"/>	Day / Month / Year <input type="text"/>	<input type="checkbox"/> Self Signing	<input type="checkbox"/> Authority
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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 <input type="text"/>	Relationship <input type="text"/>	Contact phone <input type="text"/>
	Basis of authority (e.g. parent of child under 16 years of age) <input type="text"/>		

Transfer of Records from another Practice:

In order to get the best coordinated healthcare, I ask this practice to request that my medical records are transferred from my previous practice. I also understand that I will be removed from the register of my previous practice.

Yes No N/A Previous practice:

*Fields with an asterisk must be filled in.

Patient Enrolment Form continued...

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 entitlement 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)	<input type="checkbox"/>
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	<input type="checkbox"/>
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)	<input type="checkbox"/>
e	I am an interim visa holder who was eligible immediately before my interim visa started	<input type="checkbox"/>
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	<input type="checkbox"/>
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 and control of the Chief Executive of the Ministry of Social Development	<input type="checkbox"/>
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)	<input type="checkbox"/>
i	I am participating in the Ministry of Education Foreign Language Teaching Assistantship scheme	<input type="checkbox"/>
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	<input type="checkbox"/>

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 this practice I will be included in the enrolled population of the Primary Health Organisation (PHO) this practice is contracted to, 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 understand that I am only entitled to be enrolled at Lincoln University Student Health and Support whilst enrolled as a current student at Lincoln University.

For security reasons all requests for medical information to be emailed will be declined. Please collect your information before leaving University for overseas.

Signatory Details	Signature	Day / Month / Year	<input type="checkbox"/>	<input type="checkbox"/>
			Self Signing	Authority

After completing this form please print it, sign it and post to:

Student Health, PO Box 85084, Lincoln University, Lincoln 7674, Christchurch