Patient Enrolment Form
Student Health and Support

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

Transfer of notes: GP to GP Preferred EDI lincuniv	MC 13145 Dr. Hamish Dunn	NHI Number (office use only)	Student ID number

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:*

Smoker: ☐ Ex-smoker: ☐ Never smoked: ☐

☐ If yes, would you like support to quit?

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 child under 16 years of age)		

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: ______

Patient Survey	From time to time we may contact you and ask for your feedback on your experience of care. This provides important information which we use to improve health services. Participation is voluntary and anonymous		
Patient Survey Contact Details	☐ As provided (or)	Alternative Mobile Phone	Alternative Email Address
	☐ No, I do not wish to participate in the Patient Survey		

*Fields with an asterisk must be filled in.

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New Zealand's specialist land-based university

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)	☐
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 and 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 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 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

After completing this form either

A. **Print it, sign it and post** to Student Health, PO Box 85084, Lincoln University, Lincoln 7674, Christchurch or

B. **Print it, sign it, scan the document, then email** it to healthsupport@lincoln.ac.nz