# Patient Enrolment Form

## Student Health and Support

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

Pegasus™ | LINCOLN UNIVERSITY TE WHARE WĀNAKA O AORAKI

* Mandatory Details

Anyone over the age of 16 years must complete their own enrolment form

| **Transfer of notes: GP to GP** | **EDI LINCUNIV MC9999 Dr. Student Health** | **NHI Number** (office use only) | **Student ID number** |
|---|---|---|---|

Family name:* First name:* Middle name(s):*

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

Gender: ☐ 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:***

House (or Rapid) Number and Street Name, not a PO Box/Private Bag

Street:

Suburb:

City:

Postcode:*

**Postal address:** (If different from physical address)

House (or Rapid) Number and Street Name/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 **Less** than 15 months ago | ☐ Ex-smoker **More** than 15 months ago | ☐ Never smoked |
|---|---|---|---|

If yes, would you like support to quit? ☐ Yes ☐ No

| **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 |
| | Practice name/previous doctor | Address/location | |

| **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) | | |

Form continued over page...

# Patient Enrolment Form continued...

## My declaration of entitlement and eligibility*

| | |
|---|---|
| **I am entitled to enrol** because I am residing permanently in New Zealand.<br>*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/health care services

**I understand** that by enrolling with Lincoln University Student Health and Support, I will be included in the enrolled population of Pegasus PHO and my name and address and other identification details will be included on the Practice, PHO and National Enrolment Services 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 informed** about the benefits and implications of enrolment and the services this practice and PHO provides.

**I agree to inform** the practice of any changes in my contact details and entitlement and/or eligibility to be enrolled

**I understand** that under the privacy laws my doctor may pass information to other health organisations to be used in a non-identifiable manner for health statistics. For funding purposes my doctor may be required to provide some identifiable information to other health organisations. I understand that my information may be used to include me in health screening programs. If I should need emergency or after hours care, relevant medical information in my file may be accessed by external authorized people. For details of practice policy regarding privacy and confidentiality, please check website or notices in clinic.

**I am aware,** I can contact the Practice to clarify any issues that I do not understand about health information privacy. The Practice privacy policy is available on our web site. The information that 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 LU Student Health and Support may use the follow methods to contact me: mobile/txt/land-line/email/letter

**I authorise** LU Student Health and Support personnel to access LU Student Management System to confirm any demographic details and enrolment status

**I understand** that I am only entitled to be enrolled at LU Student Health and Support whilst I am a current student at Lincoln University.

| | | | | |
|---|---|---|---|---|
| **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**<br>*(where signatory is not the enrolling person)* | Full name<br>Basis of authority (e.g. parent of child under 16 years of age) | Relationship | Contact phone |

August 2020

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

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