Poutiri Wellness Centre — Enrolment Form

WBOP PHO
Western Bay of Plenty Primary Health Organisation

35 Commerce Lane, Te Puke **Phone:** (07) 573 0091 **Fax:** (07) 881 9235	**Our Practice would prefer electronic GP2GP Notes Transfer** **Our EDI is: pouwellc** Dr Dan Jackson 69702 Dr Jen Hall 69700 : Dr Joe Bourne 37222 : Dr Tim Chiari 44619	**NHI** *(Office use only)**

Fields marked with an *are compulsory

Name	**(Title)**	**Given Name***	**Other Given Name(s)**	**Family Name***
Other Name(s) (eg. Maiden name)		**Other Name(s)**		**Preferred Name**
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 & Postcode***
Postal Address (if different from above)	**House Number, Street Name or PO Box Number**	**Suburb/Rural Delivery**	**Town / City & Postcode**

Contact Details	**Mobile Phone***	**Home Phone**	**Email 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, as I am only able to be enrolled at one practice at a time in New Zealand.*		
	☐ **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***	* ☐ Māori ☐ New Zealand European ☐ Samoan ☐ Cook Island Maori ☐ Tongan ☐ Niuean ☐ Chinese ☐ Indian ☐ Other (such as Dutch, Japanese, Tokelauan). Please state	**Iwi:**	**Hapū:**
		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**
		Do you consent to TEXT messages for recalls, reminders & updates?	☐ **Yes** ☐ **No**
		Do you want to register for Manage-My-Health (to book your own appointments and see your results)?	☐ **Yes** ☐ **No**

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*	☐

AND 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 current work visa/permit and can show that I am legally able to be in New Zealand for at least 2 years (previous visas / 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 ongoing 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 this practice's Primary Health Organisation (PHO) [Western Bay PHO], 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 understand 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.

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**
	Legal basis of authority (e.g. parent of a child under 16 years of age)		

Are you interested in other Poutiri services?	☐ **Yes**	☐ **No**

If yes, please tick the services you are interested in

- ☐ Fun fitness classes, for all levels of fitness
- ☐ Employment Support
- ☐ Māmā Maia Breastfeeding and Support Groups for Māmā
- ☐ Community Nursing for Chronic Care
- ☐ Diabetes
- ☐ Asthma and Respiratory
- ☐ Whānau Ora
- ☐ Healthy Homes
- ☐ Nutrition and mara kai (creating a vegie garden at home)
- ☐ Mental Health and/ or Addiction Service

If you answered in written form, please complete below.

Please note if you answered online, your previous answers have been already added below.

Name	**Given Name**	**Other Given Name(s)**	**Family Name**		
Preferred Name (if different)					
Birth Details	**Day/Month/Year of Birth**	**Gender**	☐ **Male**	☐ **Female**	☐ **Gender diverse**
Residential Address	**House (or RAPID) Number and Street Name**		**Suburb/Rural Location**		**Town/ City & Postcode**
Contact Details	**Mobile Phone**		**Home Phone**		**Email Address**

Please complete and email to: **wellness@poutiri.org** or drop it to Poutiri, 35 Commerce Lane with your ID (**passport or birth certificate and photo ID**).
We can help you if you do not have the ID needed.

Ngā mihi nui, we look forward to getting to know your health needs.

Mahitahi – working together for wellness.