



STUDENT HEALTH CENTRE – MANAWATU

THINK Hauora - Your Primary Health Organisation

ENROLMENT FORM

Private Bag 11222, Palmerston North 4442, NZ T: +64 6 350 5533 E: studenthealth.manawatu@massey.ac.nz W: www.massey.ac.nz

GP2GP	GP: Massey University	NZMC#: 00000	EDI: masseyst
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Please complete all fields	Student ID:	NHI (Office use only)
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Name	(Title)	First Name	Middle Name(s)	Family Name
Other Name(s) (eg. preferred name)				
Birth Details		Day / Month / Year of Birth	Place of Birth	Country of birth
Gender	Sex at birth:	Gender Identity (please state):	Pronouns:	
	<input type="checkbox"/> Male <input type="checkbox"/> Female			

Address when at Massey	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	Email Address	

Emergency Contact	Name	Relationship	Mobile (or other) Phone
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Transfer of Records	<i>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.</i>	
	<input type="checkbox"/> Yes, please request transfer of my records	<input type="checkbox"/> Not applicable (eg no previous NZ doctor)
	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	<input type="radio"/> New Zealand European <input type="radio"/> Maori Iwi _____ <input type="radio"/> Samoan <input type="radio"/> Cook Island Maori <input type="radio"/> Tongan <input type="radio"/> Niuean <input type="radio"/> Chinese <input type="radio"/> Indian <input type="radio"/> Other (such as Dutch, Japanese, Tokelauan). Please state _____ _____	Community Services Card <input type="checkbox"/> Yes <input type="checkbox"/> No Day / Month / Year of Expiry Card Number Smoking/Vaping Status: <input type="checkbox"/> No Never Smoked / Vaped <input type="checkbox"/> Current Smoker <input type="checkbox"/> Ex-Smoker / Ex-Vaper <input type="checkbox"/> Current Vaper Date quit: _____ Approx. _____ per day If Current Smoker/Vaper: The best advice we can give you for your health and well-being is to quit smoking/vaping. Here at the Massey University Health Centre we can help you on your journey to wellness. Please tick if you would like to be contacted for support to quit. <input type="checkbox"/> Yes, to be contacted <input type="checkbox"/> No, no contact at this time (you may be asked again in the future)
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My declaration of entitlement and eligibility

Please complete all four sections

1.	I am entitled to enrol because I am residing permanently in New Zealand. <i>(Please tick)</i> <i>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>	<input type="checkbox"/>
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2.	I am eligible to enrol because: <i>(Please select one of the following options)</i>	
a	I am a New Zealand citizen <i>(If yes, tick box and proceed to I confirm that, if requested, I can provide proof of my eligibility below)</i>	<input type="checkbox"/>
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)	<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 OR in the control of the Chief Executive of the Ministry of Social Development	<input type="checkbox"/>
h	I am a NZ Scholarship 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"/>

3.	I confirm that, if requested, I can provide proof of my eligibility <i>(Please tick)</i>	<input type="checkbox"/>	Evidence sighted <i>(Office use only)</i>
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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 **Student Health** I will be included in the enrolled population of THINK Hauora and my name, address and other identification details will be included on the Practice, THINK Hauora and National Enrolment Service Registers.

I agree for my relevant health information to be shared with other health professionals involved with my health care & well-being.

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 THINK Hauora provides along with THINK Hauora's name and contact details.

I have read and understand the Use of Health Information Statement (v4.1 dated 6 Nov 2018). The information I have provided on the Enrolment Form will be used to determine eligibility to receive publicly funded services, as well as for other purposes as stated on the Use of Health Information Statement. 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 only current students enrolled at Massey University can be enrolled at Student Health. **I agree** to enrol with another practice if I am no longer studying at Massey University.

I agree to enrol with another practice if I move out of the Mid Central region.

4.	Signatory Details Signature	Day / Month / Year	<input type="checkbox"/>	<input type="checkbox"/>	Self Signing Authority
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NOTE: THE FORM MUST BE SIGNED & DATED THE SAME DAY YOU SUBMIT IT TO STUDENT HEALTH

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 <i>(where signatory is not the enrolling person)</i>	Full Name	Relationship	Contact Phone
Authority Details	Basis of authority (e.g. parent of a child under 16 years of age)		

MEDICAL HISTORY

NHI:
Office only

Student ID:	Name:
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PERSONAL HISTORY

Have you ever suffered from any of the following:		<input type="checkbox"/> Asthma	<input type="checkbox"/> Eczema	<input type="checkbox"/> Migraine	<input type="checkbox"/> Hay Fever
<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart disease	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Mental illness	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Stomach or duodenal	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Tropical disease (specify)		
<input type="checkbox"/> Other major illness or injury (specify):					
Have you ever been in hospital as an in-patient?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, please specify:					
Are you allergic to anything (eg food, medicines, latex, animals, etc)?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, please specify:					
What medicines or tablets do you take regularly? <i>* Please request 3 months' supply from your current GP before enrolling with us</i>					
Are you physically disabled?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, please specify:					
Immunisations:	Did you have all the usual childhood immunisations?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
Year of last immunisation (if known):	Rubella	Tetanus	Hepatitis		
Alcohol consumption:					
How many standard drinks would you consume per week:	<input type="checkbox"/> None	<input type="checkbox"/> 1-4	<input type="checkbox"/> 5-10	<input type="checkbox"/> More than 10	
For Females only: Have you had a cervical smear?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, date or month/year:		Result:	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	
Any Additional Information:					

FAMILY HISTORY

Has any blood relative had any of these diseases?

<input type="checkbox"/> Asthma	<input type="checkbox"/> Eczema	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart disease	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Glaucoma
<input type="checkbox"/> Cancer	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Mental illness	
Give details if you wish:					

	ManageMyHealth is a secure patient portal where you can access your health records, view test results and order repeat prescriptions all via an app on your phone or computer.	
	<input type="checkbox"/> Yes, please send me registration details	<input type="checkbox"/> No, not interested

“The Use of Health Information Statement” is provided below;

Use and confidentiality of your health information (fact sheet)

Your privacy and confidentiality will be fully respected. This fact sheet sets out why we collect your information and how that information will be used.

Purpose

We collect your health information to provide a record of care. This helps you receive quality treatment and care when you need it.

We also collect your health information to help:

- keep you and others safe
- plan and fund health services
- carry out authorised research
- train healthcare professionals
- prepare and publish statistics
- improve government services.

Confidentiality and information sharing

Your privacy and the confidentiality of your information is really important to us.

- Your health practitioner will record relevant information from your consultation in your notes.
- Your health information will be shared with others involved in your healthcare, and with other agencies with your consent, or if authorised by law.
- You don't have to share your health information, however, withholding it may affect the quality of care you receive. Talk to your health practitioner if you have any concerns.
- You have the right to know where your information is kept, who has access rights, and, if the system has audit log capability, who has viewed or updated your information.
- Your information will be kept securely to prevent unauthorised access.

Information quality

We're required to keep your information accurate, up-to-date and relevant for your treatment and care.

Right to access and correct

You have the right to access and correct your health information.

- You have the right to see and request a copy of your health information. You don't have to explain why you're requesting that information, but may be required to provide proof of your identity. If you request a second copy of that information within 12 months, you may have to pay an administration fee.
- You can ask for health information about you to be corrected. Practice staff should provide you with reasonable assistance. If your healthcare provider chooses not to change that information, you can have this noted on your file.

Many practices now offer a patient portal, which allows you to view some of your practice health records online. Ask your practice if they're offering a portal so you can register.

Use of your health information

Below are some examples of how your health information is used.

- If your practice is contracted to a Primary Health Organisation (PHO), the PHO may use your information for clinical and administrative purposes including obtaining subsidised funding for you.
- Your District Health Board (DHB) uses your information to provide treatment and care, and to improve the quality of its services.
- A clinical audit may be conducted by a qualified health practitioner to review the quality of services provided to you. They may also view health records if the audit involves checking on health matters.
- When you choose to register in a health programme (eg immunisation or breast screening), relevant information may be shared with other health agencies involved in providing that health programme.
- The Ministry of Health uses your demographic information to assign a unique number to you on the National Health Index (NHI). This NHI number will help identify you when you use health services.
- The Ministry of Health uses health information to measure how well health services are delivered and to plan and fund future health services. Auditors may occasionally conduct financial audits of your health practitioner. The auditors may review your records and may contact you to check that you received those services.
- Notification of births and deaths to the Births, Deaths and Marriages register may be performed electronically to streamline a person's interactions with government.

Research

Your health information may be used in research approved by an ethics committee or when it has had identifying details removed.

- Research which may directly or indirectly identify you can only be published if the researcher has previously obtained your consent and the study has received ethics approval.
- Under the law, you are not required to give consent to the use of your health information if it's for unpublished research or statistical purposes, or if it's published in a way that doesn't identify you.

Complaints

It's OK to complain if you're not happy with the way your health information is collected or used.

Talk to your healthcare provider in the first instance. If you are still unhappy with the response you can call the Office of the Privacy Commissioner toll-free on 0800 803 909, as they can investigate this further.

For further information:

Visit www.legislation.govt.nz to access the Health Act 1956, Official Information Act 1982 and Privacy Act 2020. The Health Information Privacy Code 1994 is available at www.privacy.org.nz. You can also use the Privacy Commissioner's [Ask Us](#) tool for privacy queries. A copy of the Health and Disability Committee's Standard Operating procedures can be found at <http://ethics.health.govt.nz/operating-procedures>. Further detail in regard to the matters discussed in this Fact Sheet can be found on the Ministry of Health website at <http://www.health.govt.nz/your-health/services-and-support/health-care-services/sharing-your-health-information>