Little London Medical Clinic
ENROLMENT FORM

FIELDS WITH * ARE COMPULSORY	*Anyone over age of 16 years must complete their own enrolment form*	**NHI** *(Office use only)*

Legal Name	**Title**	* **Given Name**	***Other Given Name**	* **Family Name**
Other Name(s) (e.g. maiden name)			**Preferred Name(s)**	
Birth Details		* **Day / Month / Year**	* **Place of Birth**	* **Country of birth**
***Gender you would like to be identified as**	☐ Male ☐ Female ☐ Gender Diverse (please state)		**Sex** (at birth) ☐ Male ☐ Female	
Occupation & Employer details				

Usual Residential Address	* **House (or RAPID) Number & St**	* Suburb/Rural Location	* Town / City & Postcode
Postal Address (if different from above)	House Number & St Name or PO Box	Suburb/Rural Delivery	Town / City & Postcode

Contact Details	**Work Phone**	**Mobile Phone**	**Home Phone**	**Email Address**
Emergency Contact/NOK	**Name**	**Relationship**		**Mobile (or other) Phone**

Community Services Card	☐ Yes	☐ No	Expiry Day / Month / Year	Card Number
High User Health Card	☐ Yes	☐ No	Expiry Day / Month / Year	Card Number

*** Ethnicity Details**

Which ethnic group(s) do you belong to?

Tick the space or spaces which apply to you

- ☐ 11 **New Zealand European**
- ☐ 21 **Maori** Iwi _____
- ☐ 31 **Samoan**
- ☐ 32 **Cook Island Maori**
- ☐ 33 **Tongan**
- ☐ 34 **Niuean**
- ☐ 42 **Chinese**
- ☐ 43 **Indian**
- ☐ **Other** (such as Dutch, Japanese, Tokelauan)

Please state

Smoking is an important factor influencing health

If you are aged 15 and over please tick the space that applies for you

- ☐ Currently smoke
- ☐ Recently quit
- ☐ Ex-smoker (over 1 year)
- ☐ Never smoked

Smoking is hugely negative on your good health. In most cases, you will experience the benefits of quitting immediately.

If you currently smoke, would you like some help to quit?

☐ Yes ☐ No

Office Only: ☐ All Fields Competed ☐ Elibigility ☐ Signed & Dated ☐ NHI on form ☐ Correct date on PMS ☐ Enrolled on NES

* MY DECLARATION OF ENTITLEMENT & 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 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 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 **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 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 this practice's Primary Health Organisation (PHO) Midlands Regional Health Network Charitable Trust, 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.

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 a child under 16 years of age)		

LITTLE LONDON MEDICAL CLINIC
PATIENT HEALTH HISTORY

itsmyhealth™ Midlands Health Network

Surname: .....

First name: ... (patient stickie)....

DOB: ...../...../.....

PERSONAL HEALTH

Accidents/Injuries.....

Operations.....

Chronic Illnesses.....

Allergies.....

Hereditary Diseases.....

Known health problems.....

Current Medications.....

FAMILY HISTORY (especially heart, cholesterol, stroke, diabetes, cancer, asthma, eczema)

Mother's Health

Good ☐

Problem.....

Deceased (cause).....

Father's Health

Good ☐

Problem.....

Deceased (cause).....

Brother's/Sister's Health

Good ☐

Problem.....

Deceased (cause).....

Wider Family

Good ☐

Problem.....

SMOKING STATUS : Please **tick** the space that applies for those aged 15 and over:

Smoking status is an important factor influencing health.

☐ Never smoked ☐ No longer smoke but in the past smoked daily for more than a year ☐ Currently a smoker

LIFESTYLE

Exercise

Less than 3x weekly ☐

More than 3x weekly ☐

None ☐

Recreational Drugs

No ☐

Past Use ☐

Present Use ☐

Alcohol

Yes ☐ No ☐

How much each week?

.....

WOMEN ONLY

Do you use contraceptives? Yes ☐ No ☐ What type?.....

Number of pregnancies ..... Any complications?.....

Any menstrual problems? .....

When was your last cervical smear? ..... Any abnormal smears?.....

Have you had a mammogram? ..... If so, when.....

PHYSICAL EXAMINATION - Nursing Staff to fill in

Height..... Weight..... BP..... Blood Glucose..... Waist Circumference.....

Vaccinations Date of Last tetanus..... Date of last flu vaccination.....

Other:.....

Urinalysis Albumen..... Glucose..... Blood.....

Little London Medical Clinic

EDI: **llundonh**

Request for transfer of medical records

To: _____
(previous doctor / medical centre)

At: _____ Fax: _____(office use)
(suburb, town or city)

I authorise Little London Medical Clinic to obtain medical records from my/our previous doctor/s. I understand that I will be removed from their practice register.

(Please note that each patient aged 16 or over must complete their own transfer request but the parent or guardian must authorise the transfer of medical records for patients aged 15 or under.)

Family Name	Given Names	DOB or NHI

☐ **patient portal active?**

Signature: _____ Date: _____

Family Name	Given Names	DOB or NHI

☐ **patient portal active?**

Signature: _____ Date: _____

Family Name	Given Names	DOB or NHI

☐ **patient portal active?**

Signature: _____ Date: _____

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The doctors below are currently accepting new patients.
Little London Medical Clinic prefers to receive notes by electronic GP2GP transfer, to:

☐ Dr Anna Teata
NZMC: 28834

If GP2GP is unavailable or you are not using MedTech, and notes are sent via EDI, please print and post the inbox documents as they do not import into our system. *Thanks*.