THE UNIVERSITY OF WAIKATO
Te Whare Wānanga o Waikato

Pinnacle Incorporated

NEW PATIENT - ENROLMENT FORM

Legal Name*	(Title)	**Family Name***	**First Name(s)***		**Middle Name(s)**
Other Name(s) * (E.g: Maiden Name/Preferred Name) Please tick the name you prefer to be known as			**NHI** (office Use only)		**Student ID Number:**
Birth Details *		**Day/Month/Year of Birth***	**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 ☐ Another Term _____
Residential Address During Academic Year		☐ **Student Village** ☐ **College Hall** ☐ **Orchard Park** ☐ **Bryant Hall** ☐ **Silverdale Apartments** (Please tick which one applies if living in the halls)			
		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**	**Home Phone**	I agree to receiving Txt messages ☐ Yes ☐ No	Email Address
Emergency Contact/Next of Kin		Name		Relationship	Mobile Phone (or other)
NZAID/Manaaki Student	☐ Yes	☐ No	**Permanent Resident**	☐ Yes	☐ No

Ethnicity Details *

Which ethnic group(s) do you belong to? (Tick multiple boxes if needed, including Iwi.)

☐ New Zealand European ☐ Māori, Iwi: _____

☐ Samoan ☐ Cook Island Māori ☐ Tongan ☐ Niuean ☐ Chinese ☐ Indian

☐ Other (such as Dutch, Japanese, Tokelauan). Please state: _____

*Field with * are compulsory*

Consent to Share Health Information with other Health Providers involved in my care: ☐ Yes ☐ No

FREE PATIENT PORTAL

indici
practice anywhere

My Indici is an online portal service where you can access your health information, interact with the clinic and book appointments, and request repeat scripts free of charge.

Signup with portal: ☐ 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*	☐

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/Manaaki 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

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 the ***Student Health Service***, I will be included in the enrolled population of the Pinnacle Midlands Health Network 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 understand that while enrolled as a Student at UOW I will be charged the Standard Fee that is subsidised for students

I understand that if I choose to remain enrolled with Student Health after my studies (we encourage you to find a local Doctor) I will be charged regular GP fees and will not have access to Mental Health & Wellbeing team services (including counselling, social work, and Mental Health Nurses).

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

REQUEST TO HAVE MEDICAL RECORDS TRANSFERRED

In order to receive the best care possible, I agree to Student Health Service, University of Waikato, obtaining my medical records from my previous doctor. I also understand that I will be removed from their practice register.

Name of previous medical practice/ doctor:

_ _

_ _

Full Name: _____

DOB: _____ *or* NHI number: _____

Signature: _____ Date: _____

Office use only:

Please Suspend patient from Patient Portal Registration.

Our preference is: GP2GP/ EDI: waikatou

GP:	NZMC:	To:
Student Health Service	12345	

Student Health Service
Hauora Ākonga
The University of Waikato
Ph: 07 838 4037
Fax: 07 838 4706
Email: medcent@waikato.ac.nz

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Name: _____ **Student ID Number:** _____

Confidential Medical Information Form

This information will be used to update your medical records and help identify health needs that need follow up; a nurse may contact you to discuss your responses and/or offer support services.

1.Do you have any of the following health problems? (please tick any that apply)

☐ Asthma ☐ Epilepsy ☐ Diabetes ☐ Depression ☐ Anxiety

2. Do you have any other health conditions, inherited conditions, or disability?

☐ No ☐ Yes – please provide details _____

_____

3. Do you have, or have you had any other mental health challenges? i.e. bipolar, psychosis, personality disorders

☐ No ☐ Yes – please provide details _____

_____

4. Are you receiving care from, or have you been referred to specialist healthcare services? e.g. cardiology, psychiatry, community mental health, sexual health

☐ No ☐ Yes – please provide details _____

_____

5. Do any of your immediate family members have any serious health conditions or inherited conditions?

☐ No ☐ Yes – please provide details _____

_____

6. Do you take any regular medication? (including contraceptives & vitamins, herbal remedies or supplements)

☐ No ☐ Yes – please provide details _____

_____

7. Are you allergic to any medications or do you have any significant allergies?

☐ No ☐ Yes - please provide details of the medicine or substance and the reaction _____

_____

8. What is your smoking status?

☐ Never smoked cigarettes, or smoked less than 100 in lifetime ☐ Only Vape

☐ Stopped smoking cigarettes more than 12 months ago ☐ Stopped smoking cigarettes less than 12 months ago

☐ Current cigarette smoker

Being smokefree is one of the best things you can do for your health, would you like support to be smokefree?

☐ No ☐ Yes

9. How often do you drink alcohol? _____

How many standard drinks would you typically have in one session? _____

10. Would you like support regarding any alcohol or other drug use challenges?

☐ No ☐ Yes

11. Depression screening questionnaire (PHQ2)

Over the last 2 weeks, how often have you been bothered by the following problems?

(Scores: Not at all = 0, Several days = 1, More than half the days = 2, Nearly every day = 3)

Little interest or pleasure in doing things?	0	1	2	3
Feeling down, depressed or hopeless?	0	1	2	3

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Student Mental Health & Wellbeing Service Agreement Form

Applies to Mental Health Nurses, Counsellors, Alcohol and Other Drug clinician, Social Worker, Health Improvement Practitioners, **Health Coaches and counselling, psychology/nursing placement students.**

I agree to receive free, short-term mental health & wellbeing support at Student Health, University of Waikato. Information that I provide will be used to inform care and support provided. Care provided adheres to the Code of Health & Disability Consumer Rights (1996) and Te Tiriti O Waitangi principles.

I agree to attend all booked appointments at the arranged time and if my circumstances change, I will cancel or reschedule prior to the appointment time.

There may be times where referral to external services & agencies is required; my clinician will discuss this with me if needed.

I understand that I may be asked if a placement student can be involved in my care. I must provide consent and can decline this at any time.

I understand that Student Health keeps records of interactions I have with the service. Clinicians involved in my care at Student Health Services are able to access these. There may be times where relevant health information is shared with other members of the Student Health team or external providers with the intent of improving coordination, safety and quality of care. If I am enrolled in the practice, if I decide to enroll with another practice, my entire file is transferred including all mental health & wellbeing records. In accordance with the Privacy Act (2020) & the Health Information Privacy Code (1994), I am entitled to access health records that pertain to me.

I understand that if there are concerns for my safety or the safety of others, my clinician may have to disclose relevant information to other parties including other Student Health staff, my nominated next of kin and/or emergency services. My Clinician will keep me well informed during this process and obtain informed consent where possible.

I understand that when I cease paying the student services fee, I am no longer eligible to access mental health & wellbeing support via student health services. At this time, I will be supported to access other external support services as required.

I understand that this Service Agreement form will be held by Student Health as part of my health records.

Your consent to share personal health and wellbeing information is voluntary and you may withdraw consent at any time.

If you have any questions about this form, please contact Student Health on (07) 838 4037 OR speak with your clinician at your appointment.

By signing below, you are acknowledging you have read, understand, and agree to the above information.

STUDENT FULL NAME/ID	
SIGNATURE/ DATE	

Updated: March 2022