ST LUKE'S HEALTH CENTRE	**ENROLMENT FORM**	St Luke's Health Centre 105 Waimea Rd, Nelson, 7010 Ph (03) 548 1858 Fax (03) 548 0928 GP2GP: Dr Joseph Hassan 16512 EDI: stlukenl

FIELDS MARKED WITH AN * ARE COMPULSORY		NHI *(Office use only)*

Name *	(Title)	Given Name *	Other Given Name(s) *	Family Name *
Other Name(s)* (eg. maiden name) Please tick the name you prefer to be known as			**Occupation**	**Employer**
Birth Details *		Day / Month / Year of Birth *	Place of Birth *	Country of birth *
Gender *	☐ Male	☐ Female	☐ Gender diverse (please state)	

Usual Residential Address *	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	Email Address
Employment details	Employer	Occupation	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** **

- ○ New Zealand European
- ○ Maori
- ○ Samoan
- ○ Cook Island Maori
- ○ Tongan
- ○ Niuean
- ○ Chinese
- ○ Indian
- ○ Other (such as Dutch, Japanese, Tokelauan). Please state

Community Services Card	☐ Yes	☐ No
Day / Month / Year of Expiry	Card Number	
High User Health Card	☐ Yes	☐ No
Smoking Status (PLEASE CIRCLE ONE)	CURRENT SMOKER EX-SMOKER NEVER SMOKED	

ManageMyhealth online patient portal – do you wish to register? Yes No

Ask our reception staff who will enrol you

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 visa/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)Nelson Bays Primary Health, 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.
The information I have provided on the enrolment form will be used to determine eligibility to receive publicly funded services

PRIVACY STATEMENT. Your health Privacy: We collect your health information to provide a record of care and quality treatment when you need it. Your privacy and the confidentiality of information is very important to us. Your health information will be shared with other health professionals (e.g., Hospital or District Nursing etc.) to provide continuity of care. You do not have to consent to this information being shared,but withholding it may affect the quality of care you receive. You have the right to know where your information is kept, who has access rights and who has viewed or updated your information. You also have the right to know if your data privacy has been breached and your data has fallen into any unauthorised user's hands.

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)		