Poutiri Wellness Centre — Enrolment Form

WBOP PHO
Western Bay of Plenty Primary Health Organisation

35 Commerce Lane, Te Puke | PO Box 148, Te Puke 3153
Phone: (07) 573 0091 | Fax: (07) 881 9235 | Email: wellness@poutiri.org
Provider: Poutiri Wellness Centre |**NZMC: use # as NZMC number |EDI:** pouwellc

NHI (Office use only) *

Fields marked with an *are compulsory.

Legal Name	**Title**	**Surname/Family Name***	**First/Given Name***	
Other Name(s) (eg. Maiden name)		**Middle/Other Name(s)**	**Preferred Name**	**Maiden Name**
Birth Details		**Day/Month/Year of Birth***	**Place of Birth***	**Country of Birth***
Gender*	☐ **Male** ☐ **Female** ☐ **Gender Diverse (Please state)**			**Primary Language**

Usual Residential Address	**House (or RAPID) Number and Street Name***	**Suburb/Rural Location***	**Town/ City & Postcode***
Postal Address ***(if different from above)***	**House No, Street Name or PO Box Number**	**Suburb/Rural Delivery**	**Town / City & Postcode**
Contact Details	**Mobile Phone*** / **Home Phone**	**Email Address**	
Employer Details	**Employer and Address**	**Work Phone Number**	**Occupation**

Next of Kin/ Emergency Contact	**Name**	**Relationship**	**Mobile (or other) Phone**
	Address		

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☐	**Card Number**	**Expiry Date**
Higher User Health Card Yes☐ /No☐	**Card Number**	**Expiry Date**

Smoking Status (applies to 15yrs and over ONLY)
Never smoked ☐ Current Smoker ☐ Ex-Smoker ☐ Vape ☐

Approximate Quit Date: _____

Smoking is bad for your health. Would you like support to quit?
Yes☐ /No☐

Consent to receive communications via: (please tick applicable boxes to give your consent)

☐ **Email(non-secure)** ☐ **Text Message** ☐ **Patient Portal(secure)**

***Transfer of Records Authority**	*In order to get the best care possible, I agree to the Practice obtaining my records from my previous Doctor. I 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 NZ.*	
	☐ **Yes, please request transfer of my records** ☐ **No transfer** ☐ **Not applicable**	**Previous Doctor and/or Practice Name**
	Signature **Day/Month/Year**	**Address / Location***

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 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 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 Poutiri Wellness Centre I will be included in the enrolled population of Western Bay of Plenty Primary Health Organisation (WBOPPHO), 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.

I agree to the Terms and Conditions of Trade of Poutiri Wellness Centre and undertake to pay any fees applicable to Practice Services and all costs incurred in collection of any debt for myself and my dependents.

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)		

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

If yes, please tick the services you are interested in

- O Fun fitness classes, for all levels of fitness
- O Employment Support
- O Māmā Maia Breastfeeding and Support Groups for Māmā
- O Community Nursing for Chronic Care
- O Diabetes
- O Asthma and Respiratory
- O Whānau Ora
- O Healthy Homes
- O Nutrition and mara kai (creating a vegie garden at home)
- O Mental Health and/ or Addiction Service
- O A free Health Coach appointment to help me set and reach my health goals
- O Mirimiri
- O Support a wairua
- O Counselling

2. **Are you on regular medications?** ☐ **Yes** ☐ **No**

3. **If Yes, next script due ____ / ____ / ____**

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)			
Contact Details	**Mobile Phone**	**Home Phone**	

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

Ngā mihi nui, we look forward to getting to know your health needs. Mahitahi – working together to help you be well, get well and live well.