# STUDENT HEALTH
## ENROLMENT FORM

VICTORIA UNIVERSITY OF WELLINGTON
TE HERENGA WAKA

| Patient Details (All fields marked with * must be completed) | NHI # (office use) | |
|---|---|---|
| | Student ID Number | |

| | | | |
|---|---|---|---|
| Family Name* | | First Name* | |
| Middle Name | | Preferred Name | |
| Gender* | ☐ Male ☐ Female ☐ Other: | | |
| Preferred Pronoun | | Date of Birth* | |

Ethnicity* (Which ethnic group do you belong to? Tick the space or spaces that apply to you.)

☐ NZ European ☐ Māori ☐ Samoan ☐ Cook Island Māori ☐ Tongan ☐ Niuean ☐ Chinese
☐ Indian ☐ Other (such as Dutch, Japanese, Tokelauan). Please state:

| | | | |
|---|---|---|---|
| Address* (in Wellington, if known) | | | |
| Cellphone Number* | | Landline Number | |
| Email Address* | | | |
| Emergency Contact* | Name: | | |
| | Relationship: | Contact Number: | |
| **Community Service Card**: Number | | Expiry / / | |
| **High User Card**: Number | | Expiry / / | |
| Country of Birth | | Place of Birth | |
| Previous Medical Centre | | | |

**Alcohol and smoking intake survey: To complete survey click here.**

**As part of the enrolment process we are required to capture your smoking and alcohol intake status. Please complete this short online survey. It is completely confidential and will only be used to update your medical records.**


**Email**: mauriora@vuw.ac.nz

**Phone**: 04 463 5308

**EDI**: studhsvu
**GP2GP**: Dr Gill Mark 22282

**Postal Address**:

Student Health, Victoria University,
PO Box 600, Wellington 6140

**Physical address**:

Mauri Ora, Student Union Building,
Gate 1, Kelburn Campus, Wellington 6012

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### I am eligible and entitled to enrol because:
**[Please select one of the following options]**

- ☐ **A.** I am a New Zealand Citizen **OR**
- ☐ **B.** I hold a resident visa or a permanent resident visa (or a resident permit if issued before December 2010) **OR**
- ☐ **C.** I am an Australian citizen or Australian permanent resident AND able to show I have been in New Zealand or I intend to stay in New Zealand for at least two consecutive years **OR**
- ☐ **D.** I have a work visa/permit and can show that I am able to be in New Zealand for at least two years (previous permits included) **OR**
- ☐ **E.** I am an interim visa holder who was eligible immediately before my interim visa started **OR**
- ☐ **F.** I am a refugee or protected person or in the process of applying for, or appealing refugee or protection status, or a victim of people trafficking **OR**
- ☐ **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**
- ☐ **H.** I am 18 or 19 years old and can demonstrate that, on the 15 April 2011, I was the dependant of an eligible work permit holder **OR**
- ☐ **I.** I am a New Zealand Aid Programme student studying in New Zealand and receiving Official Development Assistance funding (or their partner or child under 18 years old)
  **Expiry Date:** ☐
  **OR**
- ☐ **J.** I am participating in the Ministry of Education Foreign Language Teaching Assistantship scheme **OR**
- ☐ **K.** I am a Commonwealth Scholarship holder studying in New Zealand and receiving funding from a New Zealand University under the Commonwealth Scholarship and Fellowship Fund.

### I choose to use this practice as my regular and ongoing provider of General Practice/GP/first level primary health care service.

- ☐ **I confirm** I wish to be an enrolled patient at this practice.
- ☐ **I understand** that by enrolling with this practice I will be removed from the register of my previous doctor.
- ☐ **I authorise** you to obtain my medical records from my previous GP.
- ☐ **I agree** that any relevant information be supplied to other registered health professionals, agencies, or hospitals when my case has been referred to them for specialist services, and that my GP will receive a report back after such a referral.
- ☐ **I agree** that any necessary information be supplied to the PHO and or/government agencies as long as the information is collected for lawful purposes connected with the contractual or statutory functions of these agencies.
- ☐ **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 understand** that when I cease paying the Student Services Levy, I am no longer eligible to use Student Health, and may be disenrolled from the practice.
- ☐ **I confirm** that if requested I can provide proof of my eligibility.
- ☐ **I agree** to inform the Practice of any changes in my eligibility.
- ☐ **I understand** this provider is a member of the Compass Health Primary Health Organisation.
- ☐ **I have read and agree** to the terms in the Health Information Privacy Statement.
- ☐ **I have completed** the alcohol and smoking intake survey.

| Signed: | Date: ☐☐/☐☐/☐☐☐☐ |
|---|---|

**Please read:** This form must be signed with an electronic signature (using tools such as Adobe Acrobat's 'Fill and Sign' option). Forms signed using typed text that has not been converted to an electronic signature cannot be accepted.

# Health Information Privacy Statement

**I understand the following:**

1. This practice holds a contract for general practice services with Tū Ora Compass Health PHO, which is a not for profit organisation contracted to support the delivery of high quality primary care services.
2. By enrolling with this Practice, I become part of the Tū Ora Compass Health PHO enrolled population. The information I have provided on the Practice Enrolment Form will be shared with Tū Ora Compass Health PHO and the Ministry of Health in order to establish my eligibility for subsidised health care. Enrolment information may also be shared with other government agencies such as Immigration NZ (where this is relevant to my enrolment eligibility) and Ministry of Social Development (where this is relevant to additional subsidies eligibility).
3. Health information about me such as medical diagnoses, laboratory test results, radiology test requests, prescribed medications, immunisations given, screening investigations such as breast screening, and other clinical and administrative data will be shared with Tū Ora Compass Health PHO who may use it to:
    a. Provide quality improvement feedback to GPs and nurses and others in my practice
    b. Plan, deliver, fund, monitor, and improve health services
    c. Contact me directly or via the Practice in relation to services I have used, or may wish to use.
4. The health information about me that is shared with the Tū Ora Compass Health PHO may change from time to time. Any information collection changes are overseen by a Tū Ora Compass Health PHO governance process and changes will be posted to the Tū Ora Compass Health PHO website.
5. My health data may be shared with external health agencies, where this is relevant to a publicly funded national or regional programme, including Breast Screening, Bowel Screening, Immunisation, Diabetes.
6. I have the right to access (and have corrected) my health information from my Practice and/or the Tū Ora Compass Health PHO under Rules 6 and 7 of the Health Information Privacy Code 2020.
7. My Health Information will only be held so long as is necessary for Tū Ora Compass Health PHO to perform its duties.
8. Members of my health team may add to my health record during any services provided to me and may share relevant health information with other health professionals who are involved in my care.
9. An electronic “Shared Care Record” allows authorised health care providers such as afterhours GPs and hospital clinicians access to a summary of information from my Practice, including laboratory test results, medical conditions, allergies, and prescribed medications. I can choose to opt out of the electronic Shared Care Record by telling my Practice, but if I choose to withhold my information, clinicians involved in my care may not immediately have important health information available when providing care to me.
10. If I visit a GP at another Practice who is not my regular doctor, I may be asked for permission to share information from the visit with my regular GP or practice. If I am under 18 or have a High User Health Card or Community Services Card and I visit another GP who is not my regular doctor, he/she can make a claim for a subsidy, and the Practice I am enrolled in will be informed of the date of that visit. The name of the Practice I visited and the reason(s) for the visit will not be disclosed unless I give my consent.
11. If my Practice is audited, my health information may be reviewed by an auditor for checking a financial claim made by the Practice. I may be contacted by the auditor to check that I have received services. If the audit involves checking health information, an appropriately qualified health care practitioner will view the health records.
12. My health information may be used for health research, but only if this has been approved by an Ethics Committee and will not be used or published in a way that can identify me. I understand that I may also be contacted and asked to consent to participate in research and that if I decline to participate this will not affect the care I receive.
13. I understand that individuals and organisations that may have access to my health information are subject to the Health Information Privacy Code, and are required to keep my information secure.
    Office of the Privacy Commissioner | Health Information Privacy Code 2020
    For more information on health information collected by Tū Ora Compass Health PHO see: tuora.org.nz