Richmond Road Medical Centre
452 Richmond Road, Grey Lynn, Auckland 1021
Tel: 09 376 5621 Fax: 09 376 5256 Email: admin@rrmc.nz

Enrolment in NZ General Practice

To complete your enrolment and to obtain subsidised healthcare we are required to sight one **or more** (see below) of the following original documents and obtain proof of your address.

Please provide the following:

A. Proof of eligibility to subsided health care.

NZ Citizens

- Passport, NZ Birth Certificate or Certificate of Citizenship.
- If only a Birth Certificate or Certificate of Citizenship is available, we will require another form of photo ID (E.G Driver's License) to confirm your identity.

Non-NZ Citizens

- Passport with Permanent residency Visa or work stamps covering at least 2 consecutive years.

Note: *If you have less than 2 years you will NOT qualify for Government subsidised health care.*
New Zealand Visitor charges will apply.

B. Address Verification: Please provide 2 separate letter/documents, with your name and address them. (e.g., bank statement header, phone, or power bill).

Office use only:

NZ Citizens - Passport, NZ Birth Certificate or Certificate of Citizenship or photo ID for address verification.

Non-NZ Resident - Passport with Permanent Residency VISA or work stamps(s) covering at least 2 consecutive years.

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Fields with * are compulsory	***Anyone over age of 16 years must complete their own enrolment form***	**NHI** *(Office use only)*

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

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	Work Phone	Email
* **Preference for communication from the practice e.g. recalls, surveys, newsletters** ☐ Email ☐ Text ☐ Phone ☐ No communication				
Emergency Contact	Name		Relationship	Mobile (or other) Phone

Transfer of Records	*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.*		
	☐ 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**
- ○ **Māori**

Iwi:_____

Hapū:_____

- ○ **Samoan**
- ○ **Cook Island Māori**
- ○ **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
Day / Month / Year of Expiry	Card Number		
Do you Smoke?	☐ Yes	☐ No (ex-smoker)	☐ Never
Disabilities:			
Comments:			

PLEASE TURN OVER TO COMPLETE MANDATORY INFORMATION

* My declaration of entitlement and eligibility *

I am entitled to enroll 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 enroll 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 Programmed student studying in NZ and receiving Official Development Assistance funding (or their partner orchild 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 the Primary Health Organization this practice belongs to 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 providesalong with the PHO's name and contact details.

I have read and I agree with the Use of Health Information Statement, which also includes information on the security and privacy of health data that is collected. 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
Authority Details	Basis of authority (e.g. parent of a child under 16 years of age)		

PLEASE TURN OVER TO COMPLETE MANDATORY INFORMATION

Richmond Road Medical Centre – New Patient Medical History Part 1

Name:	**Date of birth:**	**NHI:**

***Have you or a family member had any of the following conditions**:*

Medical Conditions	**Self**	**Family**
Diabetes	Yes / No	Yes / No
High Blood Pressure	Yes / No	Yes / No
Heart Disease	Yes / No	Yes / No
Asthma	Yes / No	Yes / No
Other Lung or respiratory disease or problems	Yes / No	Yes / No
Kidney disease or problems	Yes / No	Yes / No
Liver disease or Hepatitis	Yes / No	Yes / No
Bowel Disease	Yes / No	Yes / No
Joint Disease or problems, arthritis	Yes / No	Yes / No
Depression	Yes / No	Yes / No
Anxiety	Yes / No	Yes / No
Other Mental Health Illnesses	Yes / No	Yes / No
Blood Clot	Yes / No	Yes / No
Stroke	Yes / No	Yes / No
High Cholesterol	Yes / No	Yes / No
Epilepsy	Yes / No	Yes / No
Breast Cancer	Yes / No	Yes / No
Other Cancer	Yes / No	Yes / No
Glaucoma	Yes / No	Yes / No
Rheumatic Fever	Yes / No	Yes / No
Tuberculosis	Yes / No	Yes / No
Eczema	Yes / No	Yes / No
Migraine	Yes / No	Yes / No
Osteoporosis	Yes / No	Yes / No

New Patient Medical History *Part 2*

- Do you have any other health, disability problems or inherited conditions?

- Please list any regular medications or supplements that you take:

- Please list any operations.

- Are you allergic to any medications? If yes, please state.

- Do you smoke? Current Smoker ☐ Trying to stop ☐ *Stopped* in the last 12 months ☐ Stopped more than 12 months ago.
- Never Smoked?
- Do You Vape? Currently Vaping w/o Nicotine ☐ Currently Vaping ☐ Ex- Vaping for less 1yr ☐ Ex-Vaping more than 1yr
- Trying to give up vaping ☐ Never Vaped ☐
- Do you drink alcohol? Yes, Monthly, or less ☐ 2-4 times a month ☐ 2- 3 times a week ☐ 4 or more times a week Never ☐
- How many standard drinks on 1 day?
- How often would you have 6 or more drinks Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily ☐
- Do you take drugs or use illicit substances?
- Are you affected by anyone who takes drugs or use illicit substance?
- When was your last Tetanus booster?
- Did you receive all childhood immunisations?

Women Only *(over 25 years)*

- When was your last cervical smear?
- Have you ever had an abnormal smear result?
- Have you had a mammogram (those over 40)? If yes, please state the date.

Signature:	**Date:**

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Dr Paul Charlick 21277	**Dr Jonathan Munn 83733**	**Dr Keerthana Kamath 65471**	**Dr Shabrina Hussein 42564**
Dr Gene Dillman 67585	**Dr Neeta Haribhai 19454**	**Dr Ramya Krishnaraj 71533**	**EDI: richroad**

Transfer of Records

All Patients over 16 years are required to sign their own request for transfer of patient's records.

I (we) request that the medical records for those listed below be transferred to the Richmond Road Medical Centre.

Full Name	**Date of Birth**	**Signature (s)** If over 16 years, please sign individually or

Previous Medical Centre and Doctors name:

For office use:

Dear Doctor,

The above patient(s) have enrolled at this practice and have requested their notes to be transferred.
Kindly send record via GP2GP or through EDI.

Manage My Health (MMH)

The Richmond Road Patient Portal (managed by MMH) is an online service that provides enrolled patients over 16 years, with secure access to their medical information.

The portal allows patients to:

- View health summary (i.e. allergies, immunisations)
- Long term medications.
- Reminders (recalls and scheduled events)
- Order scripts.
- Book online.

Important Information:

- Access to the Portal is voluntary. Should you choose to opt-in, you will always have the option to opt-out.
- Portals must not be used in an emergency.

We will register when you enrol, you will **receive an EMAIL confirmation** from MMH. You must follow the instructions to complete your activation.

Patient to complete:

Name	Date of Birth	Email address to be used

Signature:	Date:

Did not Attend (DNA) Policy

Most of our Patients know it can sometimes be difficult to get a routine appointment with a GP or Nurse. During events where demand is unpredictable, that cannot easily be remedied.
One thing that makes this more difficult to overcome is the problem of missed routine appointments – DNAs.
Where patients have been declined routine appointments because the consultations are fully booked, it is at best disappointing when one of those booked appointments does not turn up and has not contacted the Practice to cancel the appointment so that it can be released for others **or** telephones so late as to make it impossible to allocate to another Patient.
Remember that your DNA is other patient's denied appointment.

DNA Policy

A DNA occurs when an appointment is not attended, and the Patient has not contacted the Practice in advance to cancel it or where the cancellation is so late as to make it impossible to allocate that time to another Patient who needs treatment.
The Practice will code this DNA, and this will prompt a retrospective check on the number of DNAs recorded against that person. Whilst we are primarily concerned with our own appointment observance, consideration may also be given to any hospital appointments where we have been notified that a Patient has failed to attend. A re-referral on the part of the GP (more GP time) will often be required by the hospital department so that the Patient can be recalled.

DNA 1 -Where this is the first occasion, a code will be added to the Patient's medical record and the DNA counted in a monthly search. A letter will be sent to the patient advising of the matter, and to contact the surgery if this has been sent in error.

DNA 2- Where this is the second occasion, the Patient will be sent a second letter by the Practice, advised of the missed appointment, and asked to make an appointment with the admin team to explain if there were reasonable grounds for the non-attendance on this occasion.

DNA 3-Where a third DNA has occurred, the Practice will review the individual case and a decision will be taken with regards to addressing the Patient's future ability to prebook routine appointments. Patients will be sent an invoice for the full charge of the missed appointment.

How to avoid becoming a DNA
If you cannot attend or no longer need an appointment, please ring us in advance.
Mistakes do happen and the Practice understands that appointments can be forgotten about or overlooked. In such cases, the Practice will consider the reason given by patients.
Preference, of course, is for the Practice to know in advance so we can offer the appointment(s) to other Patients in need.

Patient signature:	**Date:**

We are required by the NZ Ministry of Health to ensure that Patients are aware of the following.

Health Information Privacy Statement

I understand the following:

Access to my health information: I have the right to access (and have corrected) my health information under Rules 6 and 7 of the Health Information Privacy Code 1994.

Visiting another GP: If I visit another GP who is not my regular doctor, I will be asked for permission to share information from the visit with my regular doctor or practice. If I 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.

Patient Enrolment Information: The information I have provided on the Practice Enrolment form will be:

- Held by Practice.
- Used by the Ministry of Health to give me a National Health Index (NHI) number, or update any changes sent to the PHO and Ministry of Health to obtain subsidized funding on my behalf.
- Used to determine eligibility to receive publicly funded services.
- Enrollment information is protected by the medical ethics of confidentiality, the provisions of the Privacy Act 1993 and the Health Information Privacy Code 1994. See RRMC website for additional information.
- Information may be compared with other government agencies only when permitted under the Privacy Act.

Health Information: Members of my health team may:

- Add to my health record during any services provided to me and use that information to provide appropriate care
- Share relevant health information to other health professionals who are directly involved in my care.

Audit: In the case of financial audits, my health information may be reviewed by an auditor for checking a financial claim made by the practice, but only according to the terms and conditions of section 22G of the Health Act (or any subsequent applicable Act). I may be contacted by the auditor to check that services have been received. If the audit involves checking on health matters, an appropriately qualified health care practitioner will view the health records.

Health Programs: Health data relevant to a program in which I am enrolled (e.g. Breast Screening, Immunization, Diabetes) may be sent to the PHO or the external health agency managing this program.
Other uses of Health Information: Health information which will not include my name but may include my National Health Index identifier (NHI) may be used by health agencies such as the District Health Board, Ministry of Health, or PHO for the following purposes, if it is not used or published in a way that can identify me:

- health service planning and reporting
- monitoring service quality
- Payment

Research: 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. Except as listed above, I understand that details about my health status or the services I have received will remain confidential within the medical practice unless I give specific consent for this information to be communicated.

Patient signature:	**Date:**