STUDENT HEALTH
ENROLMENT FORM

TE WHARE WĀNANGA O TE ŪPOKO O TE IKA A MĀUI VICTORIA UNIVERSITY OF WELLINGTON

Patient Details (All fields marked with * must be completed)	NHI #	
	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*			
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		Fax number:	

Smoking status (tick one)

☐ Never smoked ☐ Passive smoker ☐ Ex-smoker (from: to:) ☐ Current smoker (quantity of cigarettes per day:)

Email: student-health@vuw.ac.nz

Phone: 04 463 5308
Fax: 04 463 5028

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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VICTORIA UNIVERSITY OF WELLINGTON

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

Signed (insert electronic signature):	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.