Te Kāika

Whānau Enrolment Form

Date form received ___/___/___
(Office Use Only)

Requested Services

Indicate the service that you are requesting by choosing from the options provided below

Taha Tinana

- ☐ GP Practice
- ☐ Community Dental
- ☐ Community Nursing Service
- ☐ Immunisations
- ☐ Quit Smoking
- ☐ Podiatrist

Taha Hinegaro

- ☐ AOD & Mental Health
- ☐ Maternal Mental Health
- ☐ Communicable Diseases
- ☐ Gambling Harm
- ☐ Lifestyle Service

Taha Wairua

- ☐ Counselling
- ☐ Mirimiri
- ☐ Rongoa Maori
- ☐ Advocacy and Support
- ☐ Dietician

Taha Whānau

- ☐ Aged Care
- ☐ Rangatahi Services
- ☐ Hapū Māmā Services
- ☐ Pēpi Services
- ☐ Tamariki Ora Service (Wellchild)
- ☐ Health Improvement Practitioner

Personal Information

First Name _____ Last Name _____ Preferred Name _____

Address _____ Suburb _____ Town/City _____ Postcode _____

Date of Birth ___/___/___ Gender: ☐ Male ☐ Female Gender Diverse (please state) _____

Mobile Phone _____ Home Phone _____ Email _____

Ethnicity: ☐ Māori ☐ New Zealand European ☐ Cook Island Māori ☐ Samoan ☐ Tongan ☐ Chinese
☐ Other European ☐ Filipino ☐ Indian ☐ Other Please State: _____ Iwi: _____

Parent Name _____ Parents NHI _____ Contact Phone _____

Referral Details

Reason _____ Referrer Name: _____ Referrer Signature: _____

Referral Type: ☐ Self-Referral ☐ Referred by Staff ☐ Website ☐ Word of Mouth ☐ Agencies

Medical Information

NHI _____ GP Practice _____ Doctor _____ Contact Number: _____

Emergency Contact

Contact Name _____ Relationship _____ Contact Number: _____

Next of Kin _____ Relationship _____ Contact Number: _____

Initial Needs Assessment

A. Do you have any dependents in your care at present that may require access to additional support? ☐ Yes ☐ No

B. Do you or have you ever had a respiratory condition? ☐ Yes ☐ No

C. Do you or have you ever had a heart condition? ☐ Yes ☐ No

D. Do you or have you ever had diabetes? ☐ Yes ☐ No Type 1 ☐ Type 2 ☐ Unknown ☐

E. Date last seen by GP or nurse for a diabetes check _____

F. Have you had a retinal (eye) screening done in the last 2 years? ☐ Yes ☐ No

G. Do you or have you ever smoked? _____ ☐ Yes ☐ No

H. If you stopped smoking, how long ago did you stop? _____

I. Do you or have you ever vaped? ☐ Yes ☐ No

J. Do you or any one in your household have any concerns of mental and physical health? ☐ Yes ☐ No

I have reviewed the information on this form, and it is accurate to the best of my knowledge. I understand that this information will be used by People & Capability to determine the appropriate pathway into one or more services provided above.

_____ Signature

_____ Date

www.tekaika.nz

03 471 9960

25 College Street
Caversham
Dunedin

PO Box 3128
Caversham
Dunedin

Whānau Enrolment Form

Te Kāika

Medical History

Are you presently in pain? ☐ Yes ☐ No

Are you enrolled with a GP? ☐ Yes ☐ No

Are you being treated for any health-related conditions? ☐ Yes ☐ No

Are you taking any medications, if so please list below:

Check off if you've had any of the following:

- ☐ Arthritis
- ☐ Epilepsy
- ☐ Asthma
- ☐ Stroke
- ☐ Herpes
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ HIV+/Aids
- ☐ Respiratory
- ☐ Migraine/Headaches
- ☐ Liver Disease
- ☐ Blood Transfusion
- ☐ Fainting Spells
- ☐ Thyriod Disease
- ☐ Artificial Joints/Prosthesis
- ☐ High Blood Pressure
- ☐ Gastric Problems
- ☐ Chest & Lung Disease
- ☐ Cancer Treatment
- ☐ Depressive Illness
- ☐ Kidney Problems
- ☐ Nervous Disorders
- ☐ Diabetes
- ☐ Heart Murmur
- ☐ Heart Trouble
- ☐ Rheumatic Fever
- ☐ Heart Surgery

Do you have or have you had any other diseases or medical problems not listed on this form?

List any known Allergies

Dental History

Is any part of your mouth sensitive to the following?

Hot ☐ Cold ☐ Bitting Pressure ☐ Sweets ☐ Other

Acknowledgement

- I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge.
- I understand that this information will be used by the Dentist or Practice to determine the appropriate management of my treatment.
- If there is any change in my medical status, I will inform the Dentist or the Practice.
- New Patient or the Parent/Guardian to please sign the Informed Consent section provided below.

Consent Process

- I am aware that I have the right to access current information held by Te Kaika
- I accept that non-identifying statistical information is collected and used by Te Kaika Social Service and our funding providers and approval agencies such as the Ministry for Health and that Te Kaika will meet the requirements and principles of (1)b - 1(d) & 2(b), 2(d) of the Privacy Act 2020 and Health and Disability Services Act 2000.
- Identifiable information you give us will not be released to unauthorised persons or external parties without us contacting you in the first instance to obtain your permission, unless the release of information is necessary for your safety or the safety of your children as per section 51S - 3(e) and (f) of the Family Violence Act 2018 and sections 6, 13 and 15 of the Oranga Tamariki Act 1989.
- I understand that nothing in this consent overrides those acts which allow for sharing and reporting of serious risk of harm to a child, self or others.
- I understand that Te Kaika requires open communication and correct details to bring about care
- I am aware of my right to withhold or withdraw consent to Te Kaika or agency involved at any time.
- I understand that Te Kaika have the reciprocal right to safety and respect and that if breached, Te Kaika has the right to withdraw the provided service.
- I understand that I have the right to make a complaint; this can be done anonymously or to People & Capability if I am dissatisfied with the way I have been treated.
- I understand that I may seek help of an independent advocate from the Health and Safety Advocacy Services South Island, **Phone (03) 479 0265.**

Client Provides Informed Consent

Signed by the client or guardian / caregiver:	**Date:**
Full name of guardian / caregiver:	**Date:**

The above consent has been signed after the full explanation of the 'Health Information Privacy Code' (Above).

If you believe that a breach to your right of privacy has been made, you are invited to email hr@ohl.nz.