Patient Information Form (PIF)

NHI No: _____
Visit No: _____

Capital & Coast District Health Board
ŪPOKO KI TE URU HAUORA

Title: _____ Surname: _____ First Name(s): _____

Preferred Name: _____ Previous Surname(s): _____

Gender: Male ☐ Female ☐ Date of Birth: _____ Country of Birth: _____

Phone: _____ *(home)* _____ *(work)* _____ *(mobile)*

Usual Residential Address:

Postal Address (if different):

Your Email: _____ GP contact no.: _____

Usual GP: _____ GP Practice/Medical Centre: _____

NZ Residency Status

☐ Yes ☐ No ☐ Born in New Zealand ☐ Visitor Permit ☐ NZ Citizen ☐ Permanent Resident ☐ Non Resident ☐ Work Permit

Are you eligible for publicly funded healthcare in NZ?

☐ Yes ☐ No ☐ Unknown

Have you lived in NZ over 2 years?

☐ Yes ☐ No

Are you an Australian or British citizen?

☐ Yes ☐ No

Who can we contact in case of an emergency?

1. Next of Kin:

Name: _____

Address: _____

_____

Relationship to patient: _____

Ph: _____ *(hm)* _____ *(wk)*

_____ *(mob)*

2. Alternative Contact:

Name: _____

Address: _____

_____

Relationship to patient: _____

Ph: _____ *(hm)* _____ *(wk)*

_____ *(mob)*

If there is an emergency, which person should we contact first? ☐ 1 ☐ 2

Name of person holding enduring power of attorney: Name:_____ Phone:_____

Ethnicity: *Please mark the ethnic group that you belong to with the number **1**. If there is more than 1 please mark **2 or 3** in the order of preference.*

☐ NZ European ☐ Maori ☐ Other European ☐ Cook Island Maori ☐ Samoan ☐ Indian ☐ Tongan ☐ Chinese

Other (please specify) _____ Name your iwi (if applicable) _____

Do you require an interpreter? ☐ Yes ☐ No Please specify language: _____

Do you have an impairment / disability (a condition lasting more than six months?) ☐ Yes ☐ No

Please specify type: physical, intellectual/psychiatric, sensory, other: _____

ACC

Is this presentation the result of an accident?

☐ Yes ☐ No

Date of accident: / /

ACC number: _____

Description of injury:

_____

Chaplain Service

Please state the religion/denomination of your choice:

_____

Would you like a visit from the Chaplain?

_____

Cultural Care

Whanau Care Services and the Pacific Health Unit provide a range of support services. Would you like a visit from:

☐ Whanau Care

☐ Pacific Health

Declaration: To the best of my knowledge, the information that I have supplied is complete and correct. I understand that I may have to pay for my treatment if I am not eligible for publicly funded health care and / or an ACC claim is declined. I have read and understand the information on the back of this form:

_____ *(signed)* Print Name: _____

Relationship to Patient: _____ Date: _____

Office Use Only Admit Date: _____ Time: _____ Attending Dr: _____

Ward: _____ Diagnosis: _____

FVST Yes: Pos ☐ Neg: ☐ F / U: ☐ Unable: ☐ **EPOA** ☐ proof sighted and copy taken **Referral Source:** _____

Proof of eligibility sighted and copy taken: ☐ Yes _____ (staff member to sign)

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WHY WE COLLECT THIS INFORMATION

You do not have to provide the information requested on this form, or agree to the entities referred to below having access to your information, but doing so will help Capital & Coast District Health Board provide an effective, efficient service to you and all its clients.

The main purpose we collect this information and other information during your hospital stay is for your care and treatment but there are other related purposes such as: to assist with administration aspects of your care; training and education; and monitoring the quality of patient care, treatment and health outcomes of our patients and explain details about your health information that is gathered and created during your treatment at Capital & Coast District Health Board.

Capital & Coast DHB surveys patients at random to find out how satisfied they are with its service. You may be contacted and asked to provide feedback.

If you would like any of this explained further, please contact a member of staff. Please read the following notes, which further explain some questions on the form.

PATIENT'S DETAILS AND HEALTH INFORMATION

Display of Your Name
Your name will be displayed at the entrance to your room, on your bed and on the ward whiteboard. This is necessary to ensure that you are correctly identified during treatment. Please let us know if you are not happy with us displaying your name in this way.

Previous Surname(s)
We need to be able to identify you from our records so that we don't confuse you with anyone else. This means we need to know any past names you may have had, including your maiden name.

Family Doctor
We may ask your GP to give us information about you. Conversely, when you are discharged, we will send your GP a summary of the treatment services you received so that he or she can give you effective ongoing care. Please give the doctor's name and the address of the surgery. If you do not wish this information to be shared, please let us know.

Residency
Your entitlement to publicly funded health care depends on your residency status. If you were not born in NZ, you may be asked to provide proof of residency. If you are not eligible publicly funded health care, you will have to pay for your treatment.
* Immigration New Zealand may be contacted to determine your eligibility for publicly funded healthcare

Stop Smoking Support
This is an optional service to support people who decide to give up smoking. The Ministry of Health may use this information in non−identifiable form for statistical purposes and policy development.

Ethnic Group
The Ministry of Health uses this information to compile statistics that help it, among other things, develop policies for health and disability services. If you need more information ask a staff member or phone Whanau Care Services on ext. 80948.

Other DHB's
Capital & Coast operates an electronic health record system that allows staff at Hutt Valley DHB and Wairarapa DHB to access electronically stored health information about patients who have received treatment at multiple DHB s. If you seek treatment at these others DHB s, they will be able to access health information stored at Capital & Coast DHB. Similarly, Capital & Coast DHB will be able to access your health information held electronically by these other DHB s.

CONTACT PERSON'S DETAILS

It may be necessary to contact the people close to you, for example, your spouse, your close friend or neighbour. Please provide the names of two contact people and state who you wish to be contacted first. In certain circumstances, for example, if you are unconscious, we may discuss your health with these people, unless you request otherwise. Please indicate if either of these contact people has Enduring Power of Attorney (EPOA).

WHO WILL HAVE ACCESS TO YOUR INFORMATION?

Your health information may be passed to or accessed by:
* Staff and contractors of Capital & Coast District Health Board who are providing and administering your care and treatment.
* Outside agencies that assist us in this, such as medical laboratories that test samples.
* Staff of Capital & Coast District Health Board and Ministry Of Health, for health research, planning and statistical purposes. Information passed on for these purposes does not usually identify individuals.
* Staff of Hutt Valley DHB and Wairarapa DHB when providing you care and treatment at those DHB's
* External agents involved in healthcare provision and / or audit for improvement

We will not disclose your information to any other agency unless you authorise this or we are required to do so by law.

YOUR RIGHT OF ACCESS

Under the Health Information Privacy Code 1994, you have the right to request access to, and correction of, any information held about you.

For more information on your rights, see the pamphlet called:
"Your rights when receiving a Health or Disability Service".

When you have completed this form, please hand it to a staff member or return it to Capital & Coast District Health Board, Private Bag 7902, Wellington 6242