Kāhui Tū Kaha

Phone 09) 531 4040 . Fax 09) 520 4068

# ENROLMENT FORM

| **First name:** | **Surname:** |
|---|---|
| **Address:** | **Living Situation** *(please circle):* Own home / Renting / Supported accomm. / Boarding House / Rest home / Intensive Support Rehab / Homeless (no fixed abode) |
| **Date of Enrolment:** | **NHI Number:** |
| **Home phone number:**<br>**Mobile number:** | **Ethnicity:**<br>**Language/s** (e.g. English/Te Reo Maori/Cantonese): |
| **Date of Birth:**<br>**Gender:** | **E-mail address:** |
| **Community Support Worker / support person & contact number:** | |
| **Emergency contact person & contact number** (e.g. next of kin): | |
| **Clinical Key-worker:**<br>**Community Mental Health Centre:** | |
| **Are you registered with a GP?** *YES / NO* **GP Name and Contact Number:** | |
| **Medical Alerts/Allergies** (incl. medication needed)**:** | |
| **Employment status** (*please circle*)**:** Employed 30 + hours p.week / Employed Part Time / Unemployed / Retired Supported Living (Invalid's) Benefit / Job Seeker's (Sickness) benefit / Voluntary | |
| **Please list below which group/s you are interested in;** | **and outline your goals for those groups;** |
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| | |
| **Are you a smoker** *YES / NO* **If yes, how many do you smoke per day?**<br>**If yes, would you like some advice on quitting?** *YES / NO* | |
| **Please tell us how you heard about us** (e.g. my support worker told me/I received a letter in the post/etc.) | |

**Please attach a completed Informed Consent form and your most recent Wellness Plan/Relapse/Risk Management Plan.**

- I acknowledge that this information is true and correct. I give my consent to be involved in the Kupenga Ora Programme.
- I give permission for my Key-worker/GP/Support Person (e.g. next of kin)/Emergency Contact to be contacted regarding this application or any emergency situations (cross out those which don't apply).
- I understand that Kāhui Tū Kaha will be audited at times to ensure a quality service delivery, and that auditors will have access to my records. Audit reports under no circumstances will identify me in any way.
- I, acknowledge that Kāhui Tū Kaha staff and others who are involved in my treatment, support and interventions need to share health information to ensure I receive a quality service.
- *Kāhui Tū Kaha will ensure that all aspects in the Privacy Act 1993 are complied with.*
- **By signing below, I acknowledge that I understand the above mentioned;**

**Signature** of applicant**:** ........................................................................................**Date:** .......................................