PHO
Te Awakairangi Health Trust

Upper Hutt Health Centre

Ph: (04) 9201 800
Fax: (04) 9201 808
EDI: familyuh

CASUAL/VISITOR PATIENT DETAILS

NHI No:

Title	Mr Mrs Ms Miss Dr	**First* Name(s)**		**Family Name***	

***Home Address:**

***Are you a Southern Cross Member? Yes / No**

Southern Cross Member Number:_____

Gender*
☐ Male ☐ Female ☐ Diverse Gender

***Date of birth** _____/_____/_____
Day Month Year

Place / country of birth*

Have you ever been in hospital in New Zealand?
YES / NO

GP Details

GP Name:

Practice Name:

Contact * Details	**Day Phone**	**Night Phone**	**Cell Phone**

Emergency * contact	**Name of person to contact**	**Relationship**	**Phone number**	**Address**

Which ethnic group do you belong to? Mark the space(s) which apply to you *	
New Zealand European	
Māori Iwi:	
Samoan	
Cook Islands Maori	
Tongan	
Niuean	
Chinese	
Indian	
Other such as DUTCH, JAPANESE, TOKELAUAN. **Please state:**	

***Please complete this section:**

☐ I consent to treatment & understand some of my health information may be shared with other professionals who are directly involved in my healthcare and treatment. UHHC is part of the 'Shared Care Record' with Hutt & Wellington Hospitals.

☐ I understand that payment must be made at time of my consultation. **Casual patient fees will apply.**

Signature_____ **Date** _____

Office use only:

CONSULTATION NOTES PRINTED & GIVEN TO PATIENT ☐

CONSULTATION NOTES SENT TO GP VIA HEALTHLINK ☐