

Enrolment Form

Freephone 0800 840 111

Attn Health Professional: Please submit a MedicAlert® e-referral using Medtech 32 in substitution to this form (preferred)

Australasian Society of Clinical Immunology and Allergy recommends allergies must always be confirmed (authenticated) by your Health Professional.

This form is to be completed by your Health Professional

| | | | | |
|---|------------------------------|--|-----------------|-----------|
| Patient Name | | FIRST | SECOND | LAST |
| NHI #: | | Blood Group: | | NEG / POS |
| Patient Details | | | | |
| Title | Dr / Mr / Mrs / Miss / Other | | Gender (circle) | M / F |
| Date of Birth | Ethnic Status | | | |
| Postal address | | | | |
| Suburb/RD | | | | |
| City | | | Postcode | |
| Home phone | | Work phone | | |
| Mobile | | | | |
| Email | | | | |
| Emergency Contact (Family or Friend) Information | | | | |
| Relationship | | | | |
| First name | | Surname | | |
| Address | | | | |
| Suburb/RD | | | | |
| City | | | Postcode | |
| Home phone | | Work phone | | |
| Mobile | | | | |
| Email | | | | |
| Health Professional | | | | |
| Health Professional | | Reg No. | | |
| Practice name | | | | |
| Address | | | | |
| City | | | Postcode | |
| Phone | | | | |
| Advance Service Requirements* | | | | |
| Advance Directive* <i>(Attach a copy)</i> | | Emergency Action Plan* <i>(Attach a copy)</i> | | |
| Drug Trial Action Plan* <i>(Attach a copy)</i> | | EPOA - Welfare* <i>(Attach a copy)</i> | | |
| Other Information | | | | |
| Organ Donor: (circle) | Yes | | No | |
| Emblem Engraving | | | | |
| Circle up to six (6) Warnings, Allergies or Conditions | | | | |
| Select engraved conditions with first responders in mind. | | | | |
| Please note: | | | | |
| <ul style="list-style-type: none"> Emblems allow limited information due to size restrictions (maximum of 23 characters per line). Some emblems allow only two lines. Standard medical terminology abbreviations are used. | | | | |
| Reg. Health Professional Authorisation | | | | |
| Signature | | | | |
| Date signed | | | | |
| <input type="checkbox"/> I am the patient's Health Practitioner (NP/GP/RN) | | | | |
| Once form is completed, fold and seal to create your free return postage-paid envelope. Please ensure all sides are sealed. | | | | |

| | | |
|--|--|-----|
| Medical Condition / Diagnosis | | |
| Acquired immunodeficiency syndrome | Essential hypertension | |
| Alzheimer's disease / Dementia* <i>(specify)</i> | Fetal alcohol syndrome | |
| Angina | Glaucoma | |
| Anxiety | Hemophilia* <i>(specify)</i> | |
| Asperger's disorder | Hypercholesterolemia | |
| Asthma | Hypoglycemia | |
| Atrial fibrillation | Hypothyroidism | |
| Attention deficit disorder | Ischaemic heart disease | |
| Attention deficit hyperactivity disorder | Motor neuron disease | |
| Autistic disorder | Multiple sclerosis | |
| Cancer* <i>(specify)</i> | Muscular dystrophy | |
| Cerebrovascular accident / disease* <i>(specify)</i> | Organ Transplant* <i>(specify)</i> | |
| Chronic obstructive pulmonary disease | Osteoarthritis | |
| Congestive heart failure | Pervasive developmental disorder | |
| Coronary artery bypass graft | Pulmonary embolism | |
| Coronary artery disease | Renal failure | |
| Deep venous thrombosis | Rheumatoid arthritis | |
| Diabetes mellitus | Transient ischemic attack | |
| Epilepsy | Von Willebrand disorder | |
| Medical Devices | | |
| Cochlear Implant* L R or Bilateral <i>(specify)</i> | Heart Valve Replacement* Aortic / Mitral <i>(specify)</i> | |
| Hearing Aids* L R or Bilateral <i>(specify)</i> | Implanted Medical Device* Pacemaker / ICD <i>(specify)</i> | |
| Record Medical Conditions / Devices not listed | | |
| | | |
| | | |
| Medical Warnings | | |
| Anaesthesia Alert* <i>(specify)</i> | Lymphoedema Alert | |
| | No BP IV or injections L or R arm* <i>(specify)</i> | |
| | Hearing / Vision impaired* <i>(specify)</i> | |
| | SBE prophylaxis | |
| Bleomycin Therapy | Non verbal | |
| Avoid high flow oxygen | Caution MRI's | |
| CO2 Retainer | Wears contact lenses | |
| On hemodialysis | Requires Adrenaline | |
| Medication Risks | | |
| On anticoagulants | On insulin | |
| On anticonvulsants | On steroids | |
| On immunosuppressants | On thyroxine | |
| Record Allergies / Warnings not listed | | |
| | | |
| | | |
| Anaphylaxis (Please specify which Allergies are Anaphylaxis) | | |
| Has been assessed by 'CARM' (circle) | Yes | No |
| Medications (not engraved) | | |
| 1. | 5. | 9. |
| 2. | 6. | 10. |
| 3. | 7. | 11. |
| 4. | 8. | 12. |
| Please attach copy of the last prescription (if required) | | |

FreePost Authority No. 250068

Non Profit Charity

You can assist us to save our funds by affixing a stamp.

Free DX

MedicAlert® Foundation New Zealand Inc
PO Box 40028
Upper Hutt 5140

that I approve for this purpose, may access my Personal Health Information via ManageMyHealth,

- MedicAlert® requires any clinical information I provide to be authenticated by a registered medical professional;
- MedicAlert® will otherwise use and disclose my Personal Health Information in accordance with the MedicAlert® Privacy Statement, as updated from time to time;
- Use of my ManageMyHealth Account will be in accordance with the terms stated on the ManageMyHealth Website;
- MedicAlert® and its officers, directors, employees and representatives will not be liable for any claims, actions, damages, losses or consequences of any kind, whether arising from breach of contract, tort (including negligence) or otherwise, under or in connection with this Member Statement, the Services, my Personal Health Information or my File;
- MedicAlert® may use generalised personal information or health information, which is not in a form that identifies me or any other individual, for research projects or studies of interest to the health care community;
- Upon my order and receipt of payment by MedicAlert®, MedicAlert® may provide me with additional services, subject to the specific terms and conditions (if any) applying to those additional services;
- My Membership of MedicAlert® will continue until MedicAlert® receives my resignation in writing or I die, whichever occurs first;
- I am liable for and will pay any and all fees associated with my Membership and the Services on or before the due date for payment of those fees and I agree that if I do not make timely payment of any fees associated with my Membership or the Services or have a reasonable period updated my Personal Health Information as held by MedicAlert®, MedicAlert® may cancel my Membership and/or stop providing me with some or all Services temporarily;
- All fee payments made to MedicAlert® are non-refundable and payment of fees will be deemed to be acceptance of MedicAlert®'s up to date Terms and Conditions;
- Fees charged to me will be deemed to be overdue if they remain unpaid as at 5pm on the due date for payment. MedicAlert® reserve the right to charge a fee for each overdue fees notice issued, for the purpose of recovering late/ overdue payments;
- MedicAlert® may engage a debt collection agency to collect unpaid fees charged to me, upon those fees becoming more than two (2) months overdue and I will be liable for any cost associated with recovery of unpaid fees (including court costs). I agree that a minimum debt collection agency fee may also apply;
- If I decide to resign my Membership, I will comply with MedicAlert®'s formal member resignation and service termination policy, including (but not limited to), within 5 days of the date of my resignation; paying any fees overdue, ceasing to wear a Medical ID, returning Medical IDs to MedicAlert® for destruction and disposal and forfeiting any entitlement for Services that remain unused. I agree that I must submit my resignation in writing to MedicAlert®;
- Upon MedicAlert® accepting my resignation MedicAlert® shall, to mitigate personal health risks, maintain a minimum cooling off period of 28 days from the date of receipt of my resignation, before removing my Personal Health Information from my File or destroying and disposing of my returned Medical IDs. MedicAlert® may extend the cooling off period at MedicAlert®'s discretion, if MedicAlert® considers I intend to withdraw my resignation, but am delayed in doing so;
- Should I decide within the cooling off period to change my mind and continue my Membership, any forfeited Service entitlements will be restored and my Medical ID(s) will be returned subject to all outstanding and applicable fees being received by MedicAlert®;
- I will be responsible for any fees charged by a health care provider for disclosing my Personal Health Information to MedicAlert®;
- My Membership is not transferrable to any other person. I will not attempt to assign, novate or transfer all or part of my Membership to any other person; and
- Unless I have indicated otherwise, I agree to receive by e-mail or any other method of communication chosen by MedicAlert®, information such as the MedicAlert® newsletter and information on charitable works, programs and services that may be of interest to me.

In this Member Statement:

- "Emergency Service Provider" means all emergency service organisations including (but not limited to) New Zealand Fire Service, ambulance services, Land Search and Rescue, New Zealand Police, Coastguard and Civil Defence.
 - "Good Samaritan" means someone who helps another in need.
- Please Note: The most current version of this Member Terms Statement is always available online 24 hours a day.**

MedicAlert® Foundation is a New Zealand registered incorporated society and non-profit charity. As an incorporated society, it is owned by its members. Its members are also its primary source of income to deliver its products and services, in accordance with its charitable mission.

Being a charity, the Foundation can benefit by receiving heavily discounted commercial products, services and technologies, it can also receive voluntary donations. These contribute to reducing its operating costs, which allows the Foundation to reduce its user pays fees and charges.

The Foundations Products and Services are very specialised and subject to New Zealand Law. Both Privacy and Prevention of Harm are a serious matter. For the protection of all people benefitting from the Foundations products and services, it is most important that those enrolling with the Foundation are informed of the specialised nature of the Foundations services.

Accordingly, the Foundation is legally obliged to obtain a person's informed consent and agreement to its Member Terms Statement. Please sign over the page to provide your consent and agreement to the Terms and Conditions.

Funding Support: Subject to application and approval, funding may be available through Work and Income via a Disability Allowance to fund the Foundations services for people experiencing financial hardship. Please ask your doctor for assistance to apply for the Disability Allowance, if you feel you may need financial assistance.

Informed Consent

MedicAlert® Member Terms Statement

Membership with the MedicAlert® Foundation - New Zealand Incorporated ("MedicAlert®") is conditional on an individual's acceptance of the following terms and conditions (the "Member Statement").

I acknowledge and agree that:

- MedicAlert® is an agency under the Health Information Privacy Code 1994 because it provides services in respect of health information. MedicAlert® will collect, store, use, disclose, and otherwise manage my personal information and health information that I provide to MedicAlert® or that MedicAlert® collects (together "my Personal Health Information") in accordance with the Privacy Act 1993, the Health Information Privacy Code 1994 (as amended with the Privacy time) and the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996;
- MedicAlert® will create and maintain an electronic record ("my File") containing my Personal Health Information;
- MedicAlert® will provide me with: i) a genuine MedicAlert® service supported Medical Identification ("Medical ID"), ii) access to the 24-hour MedicAlert® Emergency Hotline service; iii) a MedicAlert® Emergency Medical Card, iv) secure web-based access to my File, via ManageMyHealth, v) a MedicAlert® Global Access Service for Emergency Service and Health Care Provider use to validate your current personal and health information on file with MedicAlert® and vi) any additional services MedicAlert® agrees to provide to me (see below) (collectively the "Services");
- MedicAlert® may contact the health care providers whose names I provide to assist MedicAlert® in providing the Services to me;
- MedicAlert® will collect, use and disclose my Personal Health Information for the purposes of providing and administering the Services, including without limitation, disclosing my Personal Health Information to a Good Samaritan, Emergency Service Provider, or "health care provider" (as defined under section 3 of the Health and Disability Commissioner Act 1994) and other health professionals (collectively "Responders") who contact MedicAlert®, and may disclose my Personal Health Information to third party service providers retained by MedicAlert® to assist it in administering or providing the Services (including ManageMyHealth), where necessary, for the provision of the Services;
- MedicAlert® or Responders may contact the emergency contacts I have provided for or with information about me in case of an emergency and MedicAlert® will accept information about my health from emergency contacts and guardians listed in my File, provided the contacts and guardians know my member number; full name, date of birth, and address, but will not disclose my Personal Health Information to these contacts unless MedicAlert® believes they are one of my legal guardians or I have instructed otherwise; I will advise MedicAlert® promptly of any error in, or whether any update is required of, my Personal Health Information, MedicAlert® product or wallet card;
- I am entitled to access to, and request the correction of, my Personal Health Information by calling MedicAlert® at 0800 840 111, by logging into my ManageMyHealth account, or by writing to Membership Services, MedicAlert® Foundation NZ, CBD Towers, Upper Hutt, New Zealand;
- My guardian (if I have one), my attorney under an "Enduring Power of Attorney - Welfare" (if I have one and the power of attorney applies), or any other person