Patient Information Checklist

Patient Information	
NHI Number (if known)	
First Name	
Last Name	
Preferred Name	
Preferred Pronouns (he, she, they)	
Postal Address	
Marital Status	
Background/Culture	
Country of Birth	
NZ Citizen	☐ Yes ☐ No
NZ Residency	☐ Yes ☐ No
Ethnicity	
Preferred Spoken Language	Interpreter Required? Yes No
Iwi/hapu	
Do you have any cultural, religious, faith or spiritual beliefs or needs you would like us to be aware of? Please tell us a little bit more about this if you wish?	☐ Yes ☐ No
Occupation (or past occupation)	
Who do you live with?	
Service Providers	
GP Name & Practice	
Your current Pharmacy	
Do you have other agencies involved in your care? (e.g. District Nursing, Cancer Society, Specialists etc)	

Do you have?		
Any Allergies (medication allergies incl)		
St Johns Membership	☐ Yes ☐ No	
Medical Alarm (Bracelet/Pendant)	☐ Yes ☐ No	Would you like more information?
Advanced Care Plan	☐ Yes ☐ No	Would you like more information?

Do you have an Enduring Power of Attorney? ☐ Yes ☐ No		
	Name:	**Relationship to Patient:**
Personal Care and Welfare		
Please note: For us to act upon this we will need to have a copy on file. Property EPOA is not required.		

Priority Contact 1. Can we share your information with this person? **Yes** **No**

Title: **First Name:** **Family Name:**		
Relationship to Patient:	e.g. husband/wife/partner	
Mobile:	Home:	Work:
Email:		
Address:		

Priority Contact 2. Can we share your information with this person? **Yes** **No**

Title: **First Name:** **Family Name:**	
Relationship to Patient:	e.g. son/daughter/friend
Mobile:	
Email (if known):	

Priority Contact 3. Can we share your information with this person? **Yes** **No**

Title: **First Name:** **Family Name:**	
Relationship to Patient:	e.g. son/daughter/friend
Mobile:	
Email (if known):	

Priority Contact 4. Can we share your information with this person? **Yes** **No**

Title: **First Name:** **Family Name:**	
Relationship to Patient:	e.g. son/daughter/friend
Mobile:	
Email (if known):	