

# Patient Information Checklist



## Patient Information Checklist

Is the information on the label correct?

Yes       No

Name:
Address:
Phone Number:

Patient Information	
Preferred Name	
Preferred Pronouns (he, she, they)	
Marital Status	

Background/Culture	
Country of Birth	
NZ Residency	<input type="checkbox"/> Yes <input type="checkbox"/> No
Preferred Spoken Language	Interpreter Required?    Yes    No
Iwi/hapu	
Please list any Cultural Needs you would you like us to be aware of	
Do you have a Faith or Spiritual Beliefs that are important to you?	<input type="checkbox"/> Yes <input type="checkbox"/> No Please name or explain:
Occupation (or past occupation)	
Who do you live with?	
Service Providers	
GP (If different from the label above)	
Your current Pharmacy	
Do you have other agencies involved in your care? (e.g District Nursing, Cancer Society, Specialists etc)	

Do you have?	
Medication (or other) Allergies	
St Johns Membership	<input type="checkbox"/> Yes <input type="checkbox"/> No
Medical Alarm (Bracelet/Pendant)	<input type="checkbox"/> Yes <input type="checkbox"/> No      Would you like more information?
Advanced Care Plan	<input type="checkbox"/> Yes <input type="checkbox"/> No      Would you like more information?
Do you have an Enduring Power of Attorney? <input type="checkbox"/> Yes <input type="checkbox"/> 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.	

## Patient Information Checklist

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

<b>Title:</b>	<b>First Name:</b>	<b>Family Name:</b>
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

<b>Title:</b>	<b>First Name:</b>	<b>Family Name:</b>
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

<b>Title:</b>	<b>First Name:</b>	<b>Family Name:</b>
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

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