Client Information Form

Thank you for supporting our students during your visits.

Information you provide will be kept in your confidential client record in accordance with the Health Information Privacy code under the Privacy Act 1993

Personal Details	**Today's Date:**	
Name:	**Date of Birth:**	**NHI Number**
First Name: _____ Last Name: _____	_____ /_____ /_____	_____
Title:	**Ethnicity**	
Please select Other: _____	Please select Other: _____	
Which Clinic Are You Attending?:		
Please select		
Contact Details:	**GPs Details**	
Mobile: _____ Home:_____ Email Address:_____	Name (Dr):_____ Practice Name: _____ Phone: _____ Email: _____	
Residential Address	**Postal Address (If different to Residential)**	
Number & Street:_____ Suburb:_____ City & Post Code: _____	Number & Street:_____ Suburb:_____ City & Post Code:_____	
Emergency Contact		
Name: _____ Relationship:_____ Mobile Number: _____ Home Number: _____		

THE UNIVERSITY OF AUCKLAND
Te Whare Wānanga o Tāmaki Makaurau
NEW ZEALAND

CLINICS

UoA Clinics is a teaching and research clinic facility. Can you please complete the below questions regarding your consent to be contacted for additional services, promotions and research.		
A request to take part in research	Yes ☐	No ☐
A request to give us feedback about our service to you	Yes ☐	No ☐
University of Auckland Clinics promotions	Yes ☐	No ☐
A request to take part in teaching demonstrations	Yes ☐	No ☐
Just let us know if you change your mind in the future and we will update your records		

How did you hear about us?

You can tick more than one box

I have attended this clinic before	☐	I have attended another University of Auckland Clinic	☐
Recommended by a friend or family member	☐	Internet search	☐
Website: www.clinics.auckland.ac.nz	☐	Referral (GP, ACC etc)	☐
Kidslink	☐	Other:	☐

Advertisement: Newspaper

Other Advertisement: _____

Consent:

☐ I agree to receive clinical services by UoA Clinics and understand that this may be provided by a student with supervision from a licenced provider

☐ I agree that 1 or more student(s) may be present to observe my appointment

☐ I understand that these appointments may be recorded and used for teaching and learning opportunities within the University of Auckland

☐ I understand that I may receive a copy of my clinical notes, if requested, and this must be done in writing to clinics@auckland.ac.nz

Participant Name: _____

If applicable: Person Responsible for: _____

Your role (eg parent/guardian) _____