Enrolment and Consent Form

**Welcome to the Hearing House!**

**Please take the time to fill out this form completely and let us know if you need any help.**

This form is used for adults and children. “Client” is the person receiving the services, adult or child. When you see “your child” only complete if you are filling out this form for your child who is receiving our services.

**CLIENT DETAILS:**

**Please tell us about the client**

|  |  |
| --- | --- |
| First Name(s): | Preferred First Name(s): |
| Surname: | Male / Female / Other: |
| Address: | Date of Birth: |
| Home Phone: | National Health Index Number (NHI): |
| Email Address: | Mobile Phone: |
| What is the best way to contact you? (eg via email or mobile phone) | First Language **:** |

1. **OTHER CONTACTS:**

**Parents/Caregivers, please add your details, if the client is your child.**

**By listing these contacts you give permission to The Hearing House to discuss your care and contact these listed people**

|  |  |
| --- | --- |
|  | |
| **Person 1**  First Name(s): | Preferred First Name(s): |
| Surname: | Male / Female / Other: |
| Address:  Same as above | Relationship to client |
| Home Phone:  Same as above | Mobile Phone: |
| Email Address:  Same as above | First Language: |
| **Person 2**  First Name(s): | Preferred First Name(s): |
| Surname: | Male / Female / Other: |
| Address:  Same as above | Relationship to client: |
| Home Phone:  Same as above | Mobile Phone: |
| Email Address:  Same as above | First Language: |

1. **OTHER INFORMATION**

**Please tell us more about the client**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Is an interpreter required?** | | | Yes  No If yes, which language? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
|  | | | | | | | | |
| **What is the client’s ethnicity? You can tick more than one and specify iwi or country below:** | | | | | | | | |
| ☐ Māori  ☐ New Zealand European / Pākehā  ☐ European (other than Pākehā)  ☐ Pacific Peoples   |  |  | | --- | --- | | ☐ Samoan | ☐ Cook Islands Māori | | ☐ Tongan | ☐ Niuean | | ☐ Tokelauan | ☐ Fijian | | ☐ Other Pacific Peoples |  |   ☐ Asian   |  |  | | --- | --- | | ☐ Chinese | ☐ Indian | | ☐ Middle Eastern | ☐ Other Asian |     ☐ Other Please specify: iwi or country  ☐ I don’t want to declare | | | | | | | | |
| **What is the adult client’s highest education?** | | | | | | | | |
| Primary school | | Secondary school | | | | Diploma | | |
| Under graduate | | University degree (graduated) | | | | Post graduate | | |
| ☐ Other (please state): | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |  | | |
| **What is the client’s employment situation?**  **N/A, client is a child** | | | | | | | | |
| **Employed**  Full time  Part time | **Unemployed**  Looking for job  Not looking for job | | | **Retired** | **Voluntary work**  Hours per week \_\_\_\_\_ | | **Studying**  Full time  Part time |  |

1. **Who else is involved in the clients care?**

**Please tell us who else is working with the client**

We work together with other professionals and may need further information from them. By giving us their details, you give us permission to contact them and share medical information with them.

|  |  |  |  |
| --- | --- | --- | --- |
| **Local audiologist** | | **ENT Specialist or Otolaryngologist (ORL)** | |
| Name: | Email: | Name: | Email: |
| Address: | Phone: | Address: | Phone: |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Hearing Therapist** | | **Doctor (GP)** | |  |
| Name: | Email: | Name: | Email: | |
| Address: | Phone: | Address: | Phone: | |

|  |  |  |  |
| --- | --- | --- | --- |
| **Adviser on Deaf Children / Resource Teacher of the Deaf / Speech and Language Therapist** | | **School or Preschool** | |
| Name: | Email: | Name: | Email: |
| Address: | Phone: | Address: | Phone: |
| **Other** | | **Other** | |
| Name: | Email: | Name: | Email: |
| Address: | Phone: | Address: | Phone: |

**Local DHB** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I consent to the following information being released to The Hearing House:

* Results of audiological assessments (audiograms and reports);
* ORL assessments;
* New Born Hearing Screening;
* MRI, CT Scan results;
* Geneticists reports;
* Paediatrician’s reports

1. **PRIVACY CONSENT**

**These boxes must be ticked in order to proceed with appointments at The Hearing House**

**I confirm that:**

I have been provided with a copy of The Hearing House’s Privacy Policy (**attached** and also available at <https://www.hearinghouse.co.nz/>), which sets out how The Hearing House will collect, use and disclose my, or my child’s, personal information. I have read and understood this privacy policy.

Where I have provided information about other individuals or professionals to The Hearing House, I give permission to the Hearing House to use that information for the purposes outlined in The Hearing House’s Privacy Policy (including contacting that person to obtain my personal information and sharing my personal information with that person).

1. **VOLUNTARY CONSENTS**

**Please tick the boxes below that you consent to. It is your decision to agree to these. You can change your mind at any time – please talk to a staff member if you do change your mind. Your decision won’t affect the quality of the services we provide.**

**I consent to:**

The Hearing House contacting me about research projects.

The Hearing House using my, or my child’s, information in its research database for research purposes, in accordance with The Hearing House’s Privacy Policy (refer above). Information will be made anonymous so those outside of The Hearing House who see the research will not be able to recognize me or my child.

Other healthcare professionals observing me or my child in the clinic during an appointment I can always say no if I don’t want to be observed.

The Hearing House taking photos and/or videos of me or my child to use for training, media (including Facebook), public relations and/or fundraising purposes. I will always be asked beforehand and can say no at the time

The Hearing House can contact me about sharing my, or my child’s experiences with other families who want to know more about cochlear implant treatment.

The Hearing House sending me marketing messages about its products and/or services, initiatives including marketing/fundraising campaigns. I can unsubscribe/withdraw my consent to such messages at any time.

1. **DECLARATION AND SIGNATURE**

**Everything I have provided on this form is accurate, up to date, complete, relevant, and not misleading:**

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(or name of legal representative, and if so, relationship to client:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

**Thank you for completing these forms!**

**We look forward to welcoming you and your family to The Hearing House**

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