OFFICE USE ONLY	Client no.:	Date received: / /	Application no.:

October 2020

INZ 1260

NEW ZEALAND
IMMIGRATION

Settlement Health Assessment (Humanitarian UNHCR)

Who should use this form?

This settlement health assessment form is only for clients who are a UNHCR-mandated refugee who has been approved under:

- New Zealand's Refugee Quota Programme, or
- New Zealand's Refugee Quota Family Reunification Category.

Client notes

The information in this section will help you complete the settlement health assessment. Please read the information in this section before you start. If you wish, you can tear off the first page and keep the client notes.

Purpose of the settlement health assessment

You will be offered the settlement health assessment after your visa application has been approved. All clients approved under the above two visa categories are eligible for a settlement health assessment. This includes children and babies.

The results of this assessment will not affect your approved permanent resident visa.

The information collected during the assessment will be used to support your settlement in New Zealand. Immigration New Zealand may also provide access to health services while you are waiting for your departure to New Zealand.

Your responsibilities

Tell us the truth. False statements on the settlement health assessment may result in you not receiving the best settlement support while you are waiting to travel and when you arrive in New Zealand.

Please bring the following to your assessment appointment:

- Your original passport, certificate of identity, refugee travel document or national identity card with photo (this will be used for identification).
- Any medical reports, blood test results, X-rays, scans, vaccination certificates, current medications and anything else that is relevant to your health.
- Your glasses (spectacles) or contact lenses if you use them.
- You may bring a family member or support person to your appointment. Please let the physician know if you are bringing somebody.

During the settlement health assessment

- The settlement health assessment has questions about your medical history.
- The physician will also complete a physical examination. He or she will check your height, weight, mental state, hearing and vision, listen to your heart, lungs, feel your abdomen and check your nervous system.
- Some parts of the physical examination may be carried out by a nurse or health care assistant. You may need to remove some items of clothing for the physical examination.
- You will need to have blood tests and some other tests. You may need to go to different places to get some tests done.
- The form must be completed in English.

After the settlement health assessment

- Your physician has to wait for all your test results to complete the form. The settlement health assessment is only finalised when the physician has completed all sections of the form and attached all the test results.

Name of client	Examining physician's initials

Examining physician's notes

The information in this section will help you complete this form on behalf of a UNHCR-mandated refugee who has been approved for a New Zealand permanent resident visa under New Zealand's Refugee Quota Programme or Refugee Quota Family Reunification. Please read the information in this section before you start to complete this form.

Purpose of the settlement health assessment

The settlement health assessment must only be completed for a UNHCR-mandated refugee who has been approved for a New Zealand permanent resident visa under New Zealand's Refugee Quota Programme or the Refugee Quota Family Reunification Category.

Once their visa has been approved, these clients will be invited to undertake the settlement health assessment. All clients approved under the above two visa categories are eligible for a settlement health assessment. This includes children and babies.

The information collected on this form will be used to support the client's settlement in New Zealand. Immigration New Zealand may also use this information to provide access to health services while the client is waiting for departure to New Zealand.

The results of the settlement health assessment will not affect the client's approved permanent resident visa.

The settlement health assessment is voluntary. If the client does not undertake the assessment, Immigration New Zealand will not be able to provide the best possible settlement support. Immigration New Zealand will also be unable to assist with access to health services while the client is waiting for departure to New Zealand.

Completing the settlement health assessment

- The settlement health assessment form must be completed in English.
- If required, please organise an interpreter and chaperone for the settlement health assessment.
- Please attach two colour passport photos of the client, no more than six months old. One photo should be attached to the settlement health assessment form and one photo should be attached to the laboratory referral form.
- Please provide all relevant details about the client's health in the spaces provided. If you do not have enough space, attach a separate sheet.
- The form is finalised only when all the test results and specialist reports have been attached and you have completed all sections of the form.
- For more information on submitting this form, please see **www.immigration.govt.nz/assist-migrants-and-students/other-industry-partners/panel-physician-network**

For more information

If you have any questions about completing the form, please contact the IOM Regional Office in Canberra:

International Organization for Migration
PO Box 1009 Civic Square
Canberra ACT 2608
Australia

Telephone: +612.6267 66 00
Fax: +612.62 57 37 43
Email: MRFCanberra@IOM.INT
Website: www.iomaustralia.org

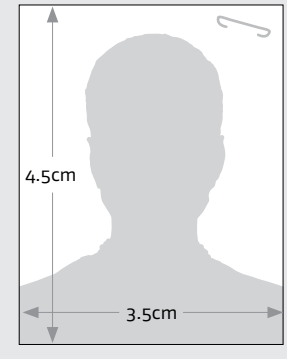
Section A Personal Details

All questions must be completed by the examining physician or delegated staff.

Please use a black pen and write neatly in English using CAPITAL LETTERS. Illegible forms will be returned for clarification. Tick or fill in all boxes.

Attach one recent passport-size photograph of the client in the space provided. The photograph must be no more than six months old. Write their full name on the back of the photograph.

A1 **Examining physician (or delegated staff member):** certify identity by placing signature and date across photograph without obscuring the likeness of the client.



☐ Valid photographic identification of client sighted

Type of identity document:

☐ Original Passport ☐ Certificate of identity

☐ Refugee travel document ☐ National ID card with photo

Identity document number

Issuing Country

Date of issue D D M M Y Y Y Y Date of expiry D D M M Y Y Y Y

A2 **Client name as shown in identity document**

Family/last name

Given/first name(s)

Title ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐ Other (specify)

A3 Gender ☐ Male ☐ Female ☐ Indeterminate **A4** Date of birth D D M M Y Y Y Y

A5 Country of birth

A6 Contact address

and/or

contact email address

A7 Under which visa category was the client's permanent resident visa approved

☐ Humanitarian UNHCR

☐ Refugee Quota Family Reunification

Either the Humanitarian UNHCR or Refugee Quota Family Reunification visa type must be selected. If the client is applying or has been approved for any other visa type, DO NOT complete this form.

Section B Consent

If the client is unable to read this consent, it is to be read to them by the staff member conducting the settlement health assessment, via an interpreter if required. If the client does not understand any part of this consent, staff conducting the assessment must provide an explanation, via an interpreter if required.

Your and / or your dependent's personal information will be collected, used, stored and disclosed by Immigration New Zealand in accordance with New Zealand law. Further information regarding how Immigration New Zealand handles personal information, including how you can access and request correction of any information can be found in Immigration New Zealand's Privacy Statement, available at **www.immigration.govt.nz/documents/online-systems/refugee-health-consent-privacy-statement.pdf**.

Settlement health assessment

- This settlement health assessment is free.
- The results of this assessment will not change the outcome of your New Zealand permanent resident visa application.
- The information collected in this assessment will be reviewed by Immigration New Zealand health specialists to determine if there are any significant health conditions you may need help with while you are waiting to travel to New Zealand.
- The settlement health assessment includes:
  - medical history questions
  - a physical examination
  - blood tests
  - a mental health assessment
  - vaccination history questions and providing any vaccinations to protect you against disease as per the New Zealand Schedule
- If you have any known health conditions, or if any new health conditions are found, then Immigration New Zealand may arrange further assessment.
- If any ongoing assessment or health management is recommended, Immigration New Zealand will help cover the cost.
- The results of the settlement health assessment may be shared with doctors and health services in this country and New Zealand who need the information to help look after your health.

The information above, has been explained to me in a language that I understand and I have had a chance to ask questions.

I understand and consent to the settlement health assessment and any further tests as a result of this assessment

☐ No ☐ Yes

I understand and consent to vaccinations being given

☐ No ☐ Yes

Signature of person being examined _____ Date D D M M Y Y Y Y

Signature of parent or guardian if person being examined is under 18 years of age

_____ Date D D M M Y Y Y Y

Full name of parent or guardian (if applicable) _____

Relationship to person being examined (if applicable) _____

Declaration of interpreter

I certify that I have given an accurate verbal translation of the above consent and believe that the client understands the contents.

Signature of the interpreter (if applicable) _____ Date D D M M Y Y Y Y

Full name of interpreter _____

Declaration of examining physician

Signature of examining physician _____ Date D D M M Y Y Y Y

Full name of examining physician _____

Section C Medical History

This section must be completed by the examining physician. Answer all questions.

If this health assessment is for a child under 18 years of age, the medical history section should be completed by the examining physician with the assistance of a parent or guardian.

History or informed of

C1 Prolonged medical treatment and/or repeated hospital admissions for any reason, including a major operation or psychiatric illness

◯ No ◯ Yes *If yes, provide details* ◯ Not answered

C2 Heart conditions including coronary disease, hypertension, valve or congenital disease

◯ No ◯ Yes *If yes, provide details* ◯ Not answered

C3 Respiratory conditions, including asthma, COPD, interstitial lung disease

◯ No ◯ Yes *If yes, provide details* ◯ Not answered

C4 Gastrointestinal conditions, including Crohn's and ulcerative colitis, or liver disease

◎ No ◎ Yes *If yes, provide details* ◎ Not answered

C5 Musculoskeletal conditions

◎ No ◎ Yes *If yes, provide details* ◎ Not answered

C6 Neurological conditions, including stroke or multiple sclerosis

◎ No ◎ Yes *If yes, provide details* ◎ Not answered

C7 Psychological or psychiatric disorder, including major depression, bipolar disorder or schizophrenia

◎ No ◎ Yes *If yes, provide details* ◎ Not answered

C8 Kidney or bladder conditions

◎ No ◎ Yes *If yes, provide details* ◎ Not answered

C9 Blood conditions including thalassemia

◎ No ◎ Yes *If yes, provide details* ◎ Not answered

C10 Hereditary or auto-immune conditions

◎ No ◎ Yes *If yes, provide details* ◎ Not answered

C11 Thyroid conditions

◎ No ◎ Yes *If yes, provide details* ◎ Not answered

C12 Communicable diseases

◎ No ◎ Yes *If yes, provide details* ◎ Not answered

C13 Hearing or vision related conditions

◎ No ◎ Yes *If yes, provide details* ◎ Not answered

C14 Do you have a hearing loss or have you noticed a decrease in your hearing?

◎ No ◎ Yes *If yes, provide details* ◎ Not answered

C15 Do you have pain in your ears?

◎ No ◎ Yes *If yes, provide details* ◎ Not answered

C16 Do you have a blocked feeling or a feeling of pressure in your ears?

◎ No ◎ Yes *If yes, provide details* ◎ Not answered

C17 Do you have tinnitus or a ringing sound in your ears?

◎ No ◎ Yes *If yes, provide details* ◎ Not answered

Only complete **C18** *if you answered 'Yes' to* **C17**.

C18 Does the tinnitus cause you stress or anxiety?

◎ No ◎ Yes *If yes, provide details* ◎ Not answered

Vision Screening

C19 Have you ever had any operations on your eyes?

◎ No ◎ Yes *If yes, provide details* ◎ Not answered

C20 Have you ever had to see an eye doctor?

◎ No ◎ Yes *If yes, provide details* ◎ Not answered

C21 Does anyone in your family have any problems with their eyes?

◎ No ◎ Yes *If yes, provide details* ◎ Not answered

C22 Do you have any difficulty doing anything because of your vision?

◎ No ◎ Yes *If yes, provide details* ◎ Not answered

Additional Questions: History or informed of

C23 an ongoing physical or intellectual disability affecting your current or future ability to work full-time

◯ No ◯ Yes *If yes, provide details* ◯ Not answered

C24 birth or developmental issues
(only for clients aged 5 or less)

◯ No ◯ Yes *If yes, provide details* ◯ Not answered

C25 an abnormal or reactive HIV blood test

◯ No ◯ Yes *If yes, provide details* ◯ Not answered

C26 an abnormal or reactive Hepatitis B or Hepatitis C blood test

◯ No ◯ Yes *If yes, provide details* ◯ Not answered

C27 cancer or malignancy in the last 5 years

◯ No ◯ Yes *If yes, provide details* ◯ Not answered

C28 diabetes

◯ No ◯ Yes *If yes, provide details* ◯ Not answered

C29 an addiction to drugs or alcohol

◯ No ◯ Yes *If yes, provide details* ◯ Not answered

C30 smoking history

◯ No ◯ Yes *If yes, provide details* ◯ Not answered

C31 any significant family health history

◯ No ◯ Yes *If yes, provide details* ◯ Not answered

C32 any medication, including contraceptives, over-the counter medication and natural supplements) ◯ No ◯ Yes *If yes, provide details* ◯ Not answered

Medication (brand and generic)	Dose	Frequency

C33 known allergies (e.g. to specific medications or food types) ◯ No ◯ Yes *If yes, provide details* ◯ Not answered

Section D Pregnancy

This section should only be completed for non-male clients, aged 6 and older.

D1 Is the client pregnant?

- ◯ No *(please move to Section E)*
- ◯ Yes *(please answer the following questions)*
- ◯ Not answered *(please move to Section E)*

D2 What is the expected date of delivery? D D M M Y Y Y Y

D3 Any complications to date?

D4 Have Rubella status, Blood group, Rhesus factor and ferritin level maternity bloods been done?

- ◯ No
- ◯ Yes *(please attach test results to this form)*
- ◯ By outside clinic

D5 Have folic acid, iron and iodine supplements been prescribed?

- ◯ No
- ◯ Yes *(please provide details of medication provided under* **C32** *)*
- ◯ Already taking

Section E Full Physical Examination

This section must be completed by the examining physician. Answer all questions.

E1 Exam date D D M M Y Y Y Y

Height and Weight

E2 Height _____ cm

E3 Weight _____ kg

E4 Body Mass Index *(only for clients 5 years and under)* _____

E5 Height percentile *(only for clients 5 years and under)*

◯ Below 5th percentile ◯ 5th to 95th percentile ◯ Above 95th percentile ◯ Not assessed

E6 Weight percentile *(only for clients 5 years and under)*

◯ Below 5th percentile ◯ 5th to 95th percentile ◯ Above 95th percentile ◯ Not assessed

E7 Head circumference *(only for clients younger than 2 years)* _____ cm

E8 Head circumference *(only for clients younger than 2 years)*

◯ Below 5th percentile ◯ 5th to 95th percentile ◯ Above 95th percentile ◯ Not assessed

Blood Pressure

E9 Systolic *(only for clients 15 years and older)* _____

E10 Diastolic *(only for clients 15 years and older)* _____

Vital Signs

E11 Temperature

◯ Normal ◯ Abnormal *If abnormal, provide details* ◯ Not assessed

E12 Respiratory rate / min *(range: 6-40)* _____

E13 Heart rate *(range: 30-200)* _____

E14 Heart rhythm

◯ Normal ◯ Atrial Fibrillation ◯ Ectopic beats ◯ Other ◯ Not assessed

Urinalysis

E15 Blood *(only for clients 5 and older)* ◯ Negative ◯ Trace ◯ 1+ ◯ 2+ ◯ 3+ ◯ Not assessed

E16 Glucose *(only for clients 5 and older)* ◯ Negative ◯ Trace ◯ 1+ ◯ 2+ ◯ 3+ ◯ Not assessed

E17 Protein *(only for clients 5 and older)* ◯ Negative ◯ Trace ◯ 1+ ◯ 2+ ◯ 3+ ◯ Not assessed

All systems

E18 Cardiovascular system

○ Normal ○ Abnormal *If abnormal, provide details* ○ Not assessed

E19 Respiratory system

○ Normal ○ Abnormal *If abnormal, provide details* ○ Not assessed

E20 Nervous system *(Sequelae of stroke or cerebral palsy, other neurological disabilities)*

○ Normal ○ Abnormal *If abnormal, provide details* ○ Not assessed

E21 Gastrointestinal system

○ Normal ○ Abnormal *If abnormal, provide details* ○ Not assessed

E22 Musculoskeletal system *(including mobility for all clients 60 or more years of age)*

○ Normal ○ Abnormal *If abnormal, provide details* ○ Not assessed

E23 Endocrine system

○ Normal ○ Abnormal *If abnormal, provide details* ○ Not assessed

E24 Eyes *(including fundoscopy)*

○ Normal ☐ Abnormal *If abnormal, provide details* ☐ Not assessed

Brain and Cognition

E25 Mental health and cognitive status

☐ Normal ☐ Abnormal *If abnormal, provide details* ☐ Not assessed

E26 Intellectual ability

☐ Normal ☐ Abnormal *If abnormal, provide details* ☐ Not assessed

Eyes, ears, nose, throat and mouth

E27 Best distance visual acuity *(with or without correction)* ☐ Correct ☐ Uncorrected ☐ Not assessed

E28

Left eye	☐ 6/6	☐ 6/9	☐ 6/12	☐ 6/18	☐ 6/24	☐ 6/36	☐ 6/60	☐ <6/60
Right eye	☐ 6/6	☐ 6/9	☐ 6/12	☐ 6/18	☐ 6/24	☐ 6/36	☐ 6/60	☐ <6/60

E29 Hearing

☐ Normal ☐ Abnormal *If abnormal, provide details* ☐ Not assessed

E30 Ear/nose/throat/mouth

☐ Normal ☐ Abnormal *If abnormal, provide details* ☐ Not assessed

Miscellaneous

E31 Developmental milestones *(4y or less)*

☐ Normal ☐ Abnormal *If abnormal, provide details* ☐ Not assessed

E32 Skin and lymph nodes

☐ Normal ☐ Abnormal *If abnormal, provide details* ☐ Not assessed

E33 BCG scar

☐ No ☐ Yes *If yes, provide details*

E34 Breast examination where clinically indicated

☐ Normal ☐ Abnormal *If abnormal, provide details* ☐ Not assessed ☐ N/A

E35 Are there any physical or cognitive conditions which may prevent this client from attending a mainstream school or gaining full employment now or in the future?

☐ No ☐ Yes *If yes, provide details* ☐ Not assessed

E36 Evidence of drug taking *(for example venous puncture marks)*

☐ Normal ☐ Abnormal *If abnormal, provide details* ☐ Not assessed

E37 Heart murmur

☐ Normal ☐ Abnormal *If abnormal, provide details* ☐ Not assessed

E38 Other abnormality on examination

☐ Normal ☐ Abnormal *If abnormal, provide details* ☐ Not assessed

Section F Settlement Vaccinations

This section should be completed by the examining physician. Please give details of any vaccines provided. If more than two vaccines are provided, please attach the details of the additional vaccines.

Vaccinations SHOULD NOT be given if the client has declined consent.

F1 Exam date D D M M Y Y Y Y

F2 Contraindications:

- ☐ Adverse reaction to former immunisation
- ☐ Temporary medical contraindication
- ☐ Medical contraindication

F3 Remarks:

F4

Disease / Vaccine	Administered by clinic	Batch Number	Batch expiry
	D D M M Y Y Y Y		D D M M Y Y Y Y

Route	◯ Subcutaneous ◯ Intramuscular ◯ Intradermal ◯ Oral ◯ Other
Site	◯ Oral ◯ Left deltoid ◯ Right deltoid ◯ Left arm ◯ Right arm ◯ Left vastus lateralis ◯ Right vastus lateralis ◯ Other
Waiver reasons	◯ Contraindicated ◯ Vaccine not available ◯ Inappropriate time for NZ schedule
Remarks	

Disease / Vaccine:	Administered by clinic:	Batch Number:	Batch expiry:
	D D M M Y Y Y Y		D D M M Y Y Y Y

Route:	◯ Subcutaneous ◯ Intramuscular ◯ Intradermal ◯ Oral ◯ Other
Site:	◯ Oral ◯ Left deltoid ◯ Right deltoid ◯ Left arm ◯ Right arm ◯ Left vastus lateralis ◯ Right vastus lateralis ◯ Other
Waiver reasons:	◯ Contraindicated ◯ Vaccine not available ◯ Inappropriate time for NZ schedule
Remarks:	

Measles, Mumps, Rubella, Hepatitis B, Polio & Varicella

F5 Test for immunity positive D D M M Y Y Y Y

Varicella

F6 Has the client had the disease? ☐ Yes ☐ No

Vaccination Documentation

F7 Full vaccination history recorded ☐ **F8** All recent vaccinations recorded ☐

Section G Laboratory Tests

This section must be completed by the examining physician on receipt of laboratory test results. The examining physician must sign and attach all test results.

Complete laboratory referral form and provide to client to take for laboratory testing if required.

Date specimen obtained	Test name	Specimen report date
D D M M Y Y Y Y		D D M M Y Y Y Y
Result		
Remarks		

Date specimen obtained	Test name	Specimen report date
D D M M Y Y Y Y		D D M M Y Y Y Y
Result		
Remarks		

Date specimen obtained	Test name	Specimen report date
D D M M Y Y Y Y		D D M M Y Y Y Y
Result		
Remarks		

Date specimen obtained	Test name	Specimen report date
D D M M Y Y Y Y		D D M M Y Y Y Y
Result		
Remarks		

Date specimen obtained	Test name	Specimen report date
D D M M Y Y Y Y		D D M M Y Y Y Y
Result		
Remarks		

Section H Chaperone and Interpreter Declaration

This declaration must be signed and dated by the chaperone and interpreter involved with this assessment (if applicable). Please read carefully before signing. Please print name and other details below.

Declaration of Chaperone

Chaperone present ☐ Yes ☐ No – not required ☐ No – offer declined

I certify that I have accompanied the client during the settlement health assessment at the request of the client.

Signature of the chaperone *(if applicable)* _____ Date D D M M Y Y Y Y

Full name of chaperone *(if applicable)* _____

Relationship to client *(if applicable)* _____

Declaration of Interpreter

Interpreter present ☐ Yes ☐ No – not required

I certify that I have assisted during the settlement health assessment and have given an accurate verbal translation of the form and believe that the client understands the contents.

Signature of the interpreter *(if applicable)* _____ Date D D M M Y Y Y Y

Full name of interpreter *(if applicable)* _____

Language *(if applicable)* _____

Section I Examining Physician Declaration

This declaration must be signed and dated by the examining physician responsible for this assessment. This declaration must be signed after the examining physician has sighted and considered all health test results. Please read carefully before signing. Please print name and other details below.

Declaration of examining physician

I certify that this person has been examined by me or staff under my supervision and their identification in terms of papers, photographs and appearance has been confirmed.

I certify that the statements my staff and I have made in answer to all the questions are true, correct and complete to the best of my knowledge.

I certify that all tests, investigations and reports I have considered are signed by me and securely attached.

Signature of examing physician _____ Date D D M M Y Y Y Y

Full name _____

Place of examination *(city, state and country)* _____

_____

Postal address _____

Daytime telephone number _____

Email address _____

Would you like Immigration New Zealand to contact you about this assessment? ☐ Yes

Mandatory attachments

- ☐ Mental Health Screening Questionnaire
- ☐ Laboratory Test Results
- ☐ Maternity Bloods (if applicable)
- ☐ Vaccine history (if applicable)
- ☐ Additional vaccines (if applicable)
- ☐ Any additional attachments

OFFICE USE ONLY	Client no.:	Date received: / /	Application no.:

May 2019

INZ 1260

NEW ZEALAND
IMMIGRATION

Laboratory Referral Form

Section J Instructions for examining physician and laboratory

Examining physician

Please provide the client details and confirm which tests are required for this client.

Please complete your contact details below.

Laboratory

Please return this form and results to the requesting examining physician.

Client's details (please print)

Client's full name

Client's date of birth D D M M Y Y Y Y

Gender ☐ Male ☐ Female ☐ Indeterminate

Laboratory tests required

Standard (compulsory) tests	Other (please specify)
☐ HbA1C	
☐ HBsAg	
☐ Hep C Antibody	
☐ Syphilis Test	
☐ Urinalysis	

Signature of examining physician

Date D D M M Y Y Y Y

Examining physician's full name

Postal address

Section K Confirmation of identity and declaration

Client

- **Present this form when having blood taken for testing.**
- **The declaration below must be completed and signed in front of the person taking blood.**

Person taking blood

☐ Valid photographic identification of client sighted

Certify identity by placing signature and date across photograph without obscuring the likeness of the client.

Client details

K1 Type of identity document

☐ Original Passport ☐ Certificate of identity

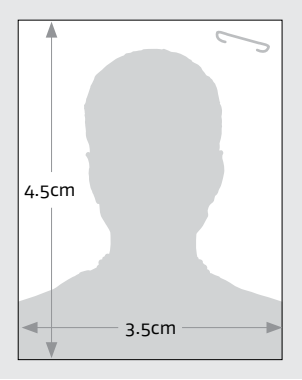
☐ Refugee travel document ☐ National ID card with photo

Identity document number

Issuing country

Date of issue D D M M Y Y Y Y

Date of expiry D D M M Y Y Y Y



K2 Client's name as shown in identity document

Family/last name

Given/first name(s)

K3 Title: ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐ Other (specify)

K4 Gender ☐ Male ☐ Female ☐ Indeterminate

K5 Date of birth D D M M Y Y Y Y

K6 Country of birth

Client's declaration

I certify that I have read and understood the consent in Section B. I understand that the consent in that section also applies to the laboratory tests.

Signature of client Date D D M M Y Y Y Y

Signature of parent or guardian if person being examined is under 18 years of age

Date D D M M Y Y Y Y

Full name of parent or guardian

Relationship to person being examined

Declaration of person assisting

I certify that I have assisted in the completion of this form at the request of the client and that the client understood the content of the form/(s) and consented to the test requirements before signing the declaration.

Signature of person assisting client (if applicable) _____ Date D D M M Y Y Y Y

Full name of person assisting _____

Declaration of person taking blood

I certify I have confirmed the client's identity in terms of papers, photographs and appearance.

Signature of person taking blood _____ Date D D M M Y Y Y Y

Full name of person taking blood _____

New Zealand Government