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

January 2021

INZ 1262

NEW ZEALAND
IMMIGRATION

Departure Health Check (Humanitarian UNHCR)

Who should use this form?

This Departure Health Check form is only for UNHCR-mandated refugees who have been:

- approved under New Zealand's Refugee Quota Programme or Refugee Quota Family Reunification Category, and
- selected on an intake for travel to New Zealand.

Client notes

The information in this section will help you complete the departure health check. 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 departure health check

You will be offered the departure health check after your visa application has been approved AND you have been selected on an intake for travel to New Zealand.

All clients approved under New Zealand's Refugee Quota Programme or Refugee Quota Family Reunification Category should have a departure health check. This includes children and babies. The results of this assessment will NOT affect your approved permanent resident visa.

The information collected during the health check will be used to assist you during your travel to New Zealand and to support your settlement in New Zealand.

Your responsibilities

Tell us the truth. False statements on the departure health check may result in you not receiving the best support during your journey and when you arrive in New Zealand.

Please bring the following to your health check 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 departure health check

- The departure health check has questions about your general medical condition. The physician 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 a chest x-ray, blood tests and some other tests if clinically necessary. Children under the age of 11 years do not need to have a chest x-ray. You may need to go to different places to get some tests done.
- The form must be completed in English.

After the departure health check

- Your physician has to wait for all your test results to complete the form. The departure health check 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, and has been selected on an intake for travel to New Zealand.

Please read the information in this section before you start to complete this form.

Purpose of the departure health check

This form 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 AND has been selected for an intake for travel to New Zealand. Once they have been selected on an intake, these clients will be invited to undertake the departure health check.

All clients approved under the above two visa categories should have a departure health check. This includes children and babies.

The information collected on this form will be used to support the client's journey to New Zealand and their resettlement in New Zealand. The results of the departure health check will not affect the client's approved permanent resident visa.

The departure health check is voluntary, but if the client does not undertake the check then Immigration New Zealand will not be able to provide the best possible travel and resettlement support.

Completing the departure health check

- The departure health check must be completed in English.
- If required, please organise an interpreter and chaperone for the departure health check.
- Please attach two colour passport photos of the client, no more than six months old. One photo should be attached to the departure health check form and one photo should be attached to the laboratory referral form.
- If this health check is for a child under 18 years of age, it should be completed by the examining physician with the assistance of a parent or guardian.
- 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 have been attached and you have completed all sections of the form. Please submit the form and all attachments within 72 hours of finalisation.

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

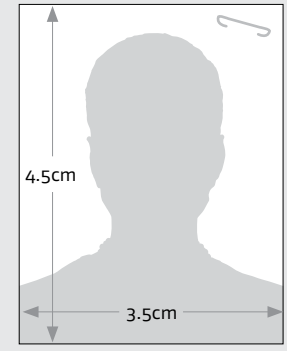
Section A Personal Details

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 departure health check, via an interpreter if required. If the client does not understand any part of this consent, staff conducting the departure health check 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**.

Departure health check

- This departure health check is free.
- The results of this health check will not change the outcome of your New Zealand permanent resident visa application.
- The departure health check includes:
  - a physical examination
  - a chest x-ray and/or tuberculosis screen
  - a mental health assessment
  - vaccination history questions and providing any vaccinations to protect you against disease as per the New Zealand Schedule
  - administration of prescribed medications required to cover your travel and arrival in New Zealand
- Immigration New Zealand will use this departure health check to:
  - Check your general health and make sure you meet airline requirements to travel to New Zealand
  - Identify any specific health needs which might need management or support during your travel to New Zealand
  - Screen for any health conditions, including tuberculosis, that may need urgent assessment or treatment
  - Support arrangement of medical care and settlement needs on arrival in New Zealand

- If any health conditions are found that may affect your ability to travel safely, Immigration New Zealand will arrange an urgent medical assessment with the aim of making sure you can travel to New Zealand as planned.
- If treatment or further testing is required that delays travel, Immigration New Zealand will assist to re-arrange your travel until treatment or further testing is complete.
- The results of the departure health check 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.

Consent

I understand and consent to the departure health check 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 General Medical Examination

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

C1 Exam date D D M M Y Y Y Y

C2 Overall physical condition ☐ Normal ☐ Abnormal *If abnormal, provide details*

_____

_____

C3 Height _____ cm

C4 Weight _____ kg

C5 Body Mass Index *(only for clients 5 years and older)* _____

C6 Zbmi _____ **C7** Zwfh _____

C8 Head circumference *(only for clients younger than 2 years)* cm

C9 Blood pressure (systolic) *(only for clients 15 years and older)*

C10 Blood pressure (diastolic) *(only for clients 15 years and older)*

C11 Heart rate *(range: 30-200)*

C12 Respiration rate / min *(range: 6-40)*

C13 Mouth and throat

☐ Normal ☐ Abnormal *If abnormal, provide details*

C14 Temperature

☐ Normal ☐ Abnormal *If abnormal, provide details*

C15 Abdominal examination for masses

☐ Normal ☐ Abnormal *If abnormal, provide details*

C16 Skin

☐ Normal ☐ Abnormal *If abnormal, provide details*

C17 Legs and feet (presence of infestations or infections)

☐ Normal ☐ Abnormal *If abnormal, provide details*

Significant Medical Conditions

C18 Hearing

☐ Normal ☐ Impaired (needs hearing aid) ☐ Deaf

C19 Vision

☐ Normal ☐ Impaired (both eyes are 6/24 or worse) ☐ Blind ☐ Cannot be assessed

C20 Learning/Development

☐ Normal ☐ Needs special attention ☐ Not able/dependent

C21 Communicating

☐ Normal ☐ Can be understood with difficulties ☐ Not able/dependent

C22 Mobility

☐ Normal ☐ Can move with difficulties ☐ Not able/dependent

C23 Current mobility aid used

C24 Mobility aid required

C25 Trauma/injury

☐ Normal ☐ Assistance required ☐ Not able/dependent

C26 Cognition

☐ Normal ☐ Assistance required ☐ Not able/dependent

Mental Health Condition

Questions C27-C32 are for clients aged 15 and older.

C27 Any of the following abnormal behaviours observed?

- Severely withdrawn

  ☐ No ☐ Yes *If yes, provide details*

- Severely agitated

  ☐ No ☐ Yes *If yes, provide details*

- Responding to non-observable external stimuli (voices/visions)

  ☐ No ☐ Yes *If yes, provide details*

- Deliberate self-harm (eg. wrist/forearm lacerations)

  ☐ No ☐ Yes *If yes, provide details*

C28 Have you ever been hospitalised or treated for a mental health problem or have you ever been suicidal?

☐ No ☐ Yes *If yes, provide details*

C29 Do you have bad memories about violence or other events which won't leave you and if so, how much do they get in the way of you being able to undertake your daily responsibilities or activities?

☐ No ☐ Yes *If yes, provide details*

C30 Have you ever believed that someone was reading your mind, controlling your mind or could put thoughts in your mind?

☐ No ☐ Yes *If yes, provide details*

C31 Have you ever head things such as voices coming from outside of your head and if so, what do they say?

☐ No ☐ Yes *If yes, provide details*

C32 Do you have thoughts of death or wishing to die which do not go away?

☐ No ☐ Yes *If yes, provide details*

Questions C33-C37 are for clients under the age of 15 and should be answered with the assistance of the client's parent/guardian.

C33 Any social withdrawal or behavioural disturbance observed?

☐ No ☐ Yes *If yes, provide details*

C34 Is your child extremely withdrawn or aggressive a lot of the time?

☐ No ☐ Yes *If yes, provide details*

C35 Are you very concerned with their behaviour in any other way?

☐ No ☐ Yes *If yes, provide details*

C36 Has your child witnessed or been directly exposed to violence and/or significant loss?

☐ No ☐ Yes *If yes, provide details*

C37 Has this resulted in abnormal behaviours?

☐ No ☐ Yes *If yes, provide details*

Other Medical Conditions present

C38 Are any of the following present

☐ Cardiovascular disorder ☐ Endocrine and metabolic disorder ☐ Eye disorder

☐ Gastrointestinal disorder ☐ Genitourinary disorder ☐ Haematology and oncology

☐ Hepatic and biliary disorder ☐ Musculoskeletal or connective tissue disorder

☐ Neurological disorder ☐ Nutritional disorder ☐ Old age and frailty ☐ Psychiatric disorder

☐ Pulmonary disorder (excluding TB) ☐ Not categorised

If present, please provide details

Pregnancy (for non-male clients aged 6 years and older only)

C39 Is the client pregnant?

◯ No ◯ Yes

C40 Estimated date of delivery D D M M Y Y Y Y

Section D Chest X-Ray and TB Screening

This section must be completed by the examining physician.

For clients aged 11 and above, please answer questions D1 – D3.

For clients younger than 11, please answer questions D4 – D10.

D1 Is a repeat x-ray required

◯ Yes ◯ No

D2 Date of x-ray D D M M Y Y Y Y

D3 Result

◯ Normal ◯ Abnormal *If abnormal, provide details*

TB Screening

D4 Is TB Screening required

◯ Yes ◯ No

D5 Exam date (date drawn/applied) D D M M Y Y Y Y

D6 Type of exam conducted

◯ Tuberculin Skin Test (TST) ◯ Interferon Gamma Release Assay (IGRA)

D7 If Tuberculin Skin Test (TST) is selected

Date of reading D D M M Y Y Y Y

D8 If Tuberculin Skin Test (TST) is selected

Millimetres of induration

D9 If Interferon Gamma Release Assay (IGRA) is selected.

Type of IGRA test

☐ Quantiferon ☐ T-Spot

D10 Result

☐ Negative ☐ Indeterminate, Borderline or Equivocal ☐ Positive

☐ If positive, indeterminate, borderline or equivocal, provide details

Section E 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

E2

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 F Travel Requirements

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

F1 Escort required?

◯ No ◯ Yes (If escort required, please answer **F2** – **F8** . If no escort required please proceed to **F9**)

F2 Escort destination

◯ Final destination ◯ Port of entry

F3 Escort type

◯ Non medical ◯ Paramedic ◯ Nurse ◯ Doctor *(if doctor, provide specialisation)*

F4 Medical condition(s) requiring escort

☐ Cardiovascular disorder ☐ Endocrine and metabolic disorder ☐ Eye disorder

☐ Gastrointestinal disorder ☐ Genitourinary disorder ☐ Haematology and oncology

☐ Hepatic and biliary disorder ☐ Musculoskeletal or connective tissue disorder ☐ Neurological disorder

☐ Nutritional disorder ☐ Old age and frailty ☐ Psychiatric disorder

☐ Pulmonary disorder (excluding TB) ☐ Not categorised

F5 Exact medical condition

F6 Exact cost of escort

F7 Escort name if known

F8 Support the escort will provide during travel

F9 Wheelchair

☐ Not required ☐ Can walk up stairs ☐ Not able to walk up stairs ☐ Carry-on passenger

F10 Seating

☐ Single ☐ Extra seat ☐ 3 seats ☐ Stretcher ☐ Business class

F11 IV Rx

☐ Not required ☐ Required

F12 Air-lift

☐ Not required ☐ Required

F13 Oxygen

☐ Not required ☐ Required *(If oxygen required, please answer* **F14** – **F17** *. If no oxygen required please proceed to* **F19** *)*

F14 Flow

F15 Delivery

☐ Continuous ☐ Intermittent

F16 To

☐ Final destination ☐ Port of entry

F17 While

☐ In transit ☐ In flight

F18 Other requirements

F19 Departure date D D M M Y Y Y Y

F20 Is there any medical condition that will delay travel?

☐ No ☐ Yes *(If Yes, please answer* **F21** – **F22** *. If no, please proceed to Section G)*

F21 Anticipated revised travel date D D M M Y Y Y Y

F22 Reason for delay

Section G Post-Arrival Requirements

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

Medical requirements on arrival

G1 Will the client have medical requirements on arrival

☐ No ☐ Yes *(If yes, please answer* **G2** – **G5** *. If no, please proceed to* **G6** *)*

G2 Ambulance at the airport?

☐ No ☐ Yes

G3 Hospitalisation

☐ No ☐ Immediate ☐ Planned

G4 Surgery

☐ No ☐ Extensive ☐ Non-extensive

G5 Other requirements

Recommended medical follow up on arrival

G6 Is medical follow up required

☐ No ☐ Yes *(If yes, please answer* **G7** – **G10** *. If no, please proceed to Section H)*

G7 Urgency

☐ Immediately (24 hrs) ☐ Within 72 hours ☐ Within one week ☐ Within one month
☐ Within six months

G8 Case Provider

☐ Family physician ☐ Counselling / Psychotherapy ☐ Specialist

G9 Details

G10 Duration

☐ Initial only ☐ Ongoing

Section H Personal Requirements

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

H1 Will the client need assistance with personal care, housing, schooling or employment?

☐ No ☐ Yes *(If yes, please answer* **H2** – **H9** *. If no, please proceed to Section I).*

H2 Personal care

☐ Fully independent, no assistance required ☐ Assistance required

H3 Amount of assistance required

☐ Manual supervision ☐ Mobile / assistance of 1 person ☐ Immobile / assistance of 2 or more persons

H4 Mobility problems, accommodation without stairs

☐ No ☐ Yes

H5 Wheelchair access

☐ No ☐ Yes

H6 Oxygen

☐ No ☐ Yes

H7 Schooling / Employment

☐ Can attend school / hold a job ☐ Needs special schooling / job arrangements
☐ Unlikely to be able to attend school / hold a job

H8 Provide details

H9 Other needs

Section I Settlement Vaccinations

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

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

I1 Exam date D D M M Y Y Y Y

I2 Contraindications

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

I3 Remarks

I4

Disease / Vaccine	Administered by clinic	Batch Number	Batch expiry
			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

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

I5 Test for immunity positive D D M M Y Y Y Y

Varicella

I6 Has the client had the disease? ☐ Yes ☐ No

Section J Settlement Medications

This section should be completed the examining physician. Answer all questions.

J1 Exam date D D M M Y Y Y Y

Parasite Medication

J2 Parasite treatment given

☐ No ☐ Yes *(If yes, please complete the following table. If no, please answer questions* **J3** – **J4** *)*

Medication	Dose	Date given
		D D M M Y Y Y Y
		D D M M Y Y Y Y

J3 Provide reason

☐ Not required ☐ Not available ☐ Declined by client ☐ Contraindicated ☐ Other

J4 Provide details

Regular Medication

J5 Has a four-month supply of regular medications been given

☐ No regular medications ☐ No *(If no, please provide details)*

☐ Yes *(If yes, please complete the following table)*

Medication	Dose	Quantity supplied	Frequency	Date given
				D D M M Y Y Y Y
				D D M M Y Y Y Y
				D D M M Y Y Y Y
				D D M M Y Y Y Y
				D D M M Y Y Y Y
				D D M M Y Y Y Y
				D D M M Y Y Y Y

Section K 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 L 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 examining 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

- ☐ Laboratory Test Results
- ☐ Vaccine history (if applicable)
- ☐ Additional vaccines (if applicable)
- ☐ Any additional attachments

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

May 2019

INZ 1262

NEW ZEALAND
IMMIGRATION

Laboratory Referral Form

Section M 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

Examining physician's laboratory reference number (if applicable)

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 N Confirmation of identity and declaration

Applicant

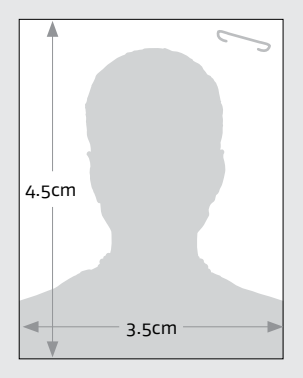
- **Present this form when having blood taken for testing.**
- **The declaration below must be completed and signed in front of the person taking blood.**

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



N1 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

N2 Client's name as shown in identity document

Family/last name | Given/first name(s)

N3 Title: ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐ Other (specify)

N4 Gender ☐ Male ☐ Female ☐ Indeterminate **N5** Date of birth D D M M Y Y Y Y

N6 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 agreed that the information provided is correct 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