RICCARTON CLINIC
your medical home

Fit to Fly Patient Information Sheet

Please Print Clearly

Family Name:	Preferred Name:	Title:
Given Name:	Date of Birth: (Day) (Month) (Year)	
Middle Names:	Gender: (circle) Male Female Gender Diverse	
Residential Address:	NZ Cell Phone:	
City: Post Code:	Country of Birth[1]:	
Email Address:		
Coming by car for swab? (circle) Yes No	If **Yes:** Car Registration/Plate number:	
Are you fully Vaccinated? (circle) Yes No		

1. Required to trace your National Health Index number

Ethnicity: [1.]	NZ European	Maori	Cook Is Maori	Chinese	Tongan	Niuean
Indian	Other European (Please state)			Other (Please state)		Declined to state

Next of Kin/ Emergency Contact Name:	Phone:	Relationship to you: (eg Mother)
Parent or Guardian details if patient is under 16 years of age:		

Flight Information	**Airline:**		
Destination			
Date & time boarding international flight NZ	Date:	Departure Time:	City:
Details if you are transiting? 1st	Date:	Departure Time: NZ Time:	City:
Details if you are transiting? 2nd	Date:	Departure Time: NZ Time:	City:
Date & Arrival time at destination:	Date:	Arrival Time: NZ Time:	City:

Fit-to-fly appointment disclaimer: Riccarton Clinic can advise customers of current fit-to-fly country guidelines, but these can change at short notice. It is, therefore, the customer's responsibility to ensure the appointment is booked to comply with the timeframes set by the country they are visiting, prior to attending the appointment. If flights are changed, or the country travelling/transiting through change their requirements, it is the customer/s responsibility to change the booking time or cover additional costs involved. The provision of results is out of the Clinic's control and the Clinic will not accept any liability for costs should the testing organisation fail to produce the results in time.

In accordance with your rights under the Code of Health and Disability Services Consumers' Rights, we will seek your informed consent before delivering any service that requires it. Under the same Rights, to ensure quality and continuity of services provided to you, we will co-operate with members of other treatment teams or other health services providers. Co-operation may require sharing of information between providers for this purpose. There are some, very limited, additional circumstances under which we have to disclose health information relating to your visit(s) here.

I agree that by engaging the Riccarton Clinic for professional services I will pay any fees incurred, both in the process of utilising those services, and any additional costs that could be incurred in the collection of any outstanding fees. I also agree to the sharing of information between providers for the purpose of ensuring quality and continuity of care.

Signed: ______________________________ Date: ________________