



Please Note results from your COVID swab may take up to **48 hours** to return and will be emailed to you and be available from Reception.

**Fit to Fly Patient Information Form** (one form per person)

Please email your completed form with a scanned copy of your passport and COVID vaccination certificate if you have one to [fittofly@moorhousemedical.co.nz](mailto:fittofly@moorhousemedical.co.nz)

<b>Family Name (as detailed on passport):</b>	<b>Title:</b>	<b>NHI:</b>	<b>APPOINTMENT DATE: TIME:</b>
<b>Given Name (as detailed on passport):</b>	<b>Date of Birth:</b>		<b>Ethnicity:</b>
<b>Middle Names (as detailed on passport):</b>	<b>Have you travelled outside of NZ in past 14 days? YES            NO</b>		<b>Gender Male    Female</b>
<b>Residential Address:</b>	<b>Passport Number:</b>		<b>Cell phone number</b>
<b>Email Address:</b>	<b>Have you tested positive for Covid 19 in the past 6 months? YES            NO</b>		<b>COVID Vaccination Dates (if applicable):</b>
<b>Next of Kin/Emergency Contact Name:</b>	<b>Phone:</b>		<b>Relationship to you:</b>
<b>Parent or Guardian details if patient is under 16 years of age</b>	<b>Name:</b>		<b>Signature:</b>

**Flight Information**

<b>Destination:</b>			
<b>Specify time frame for swab required by your airline/country of destination</b>			
<b>Date and departure time of flight leaving New Zealand:</b>	<b>Date:</b>	<b>Time:</b>	
<b>If transiting, date, time (NZ) and name place of transit departure:</b>	<b>Date:</b>	<b>Time:</b>	<b>Place:</b>
<b>Date and arrival time (NZ) at destination:</b>	<b>Date:</b>	<b>Time:</b>	<b>Destination:</b>

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 service 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 Moorhouse Medical Centre 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.

**I confirm that I have checked the specific needs for my COVID Fit to Fly test with both the airline I am flying with and the requirements of the Embassy of my destination country. The appointment time I have booked for my fit to fly test is within the timeframe as stipulated by the Embassy of the destination country and/or airline. I confirm that the information which I have provided to Moorhouse Medical Centre is accurate and correct.**

**Signed:**

**Date:**