

## Requestor Code Creation Form for Awanui Labs Hawkes Bay

### Requestors Information (Please complete all relevant shaded areas using block letters)

<b>Salutation</b>	<input type="checkbox"/> Dr	<input type="checkbox"/> Mr	<input type="checkbox"/> Ms	<input type="checkbox"/> Mrs	<input type="checkbox"/> Prof	<input type="checkbox"/> other	
<b>Job Title</b>	<input type="checkbox"/> GP	<input type="checkbox"/> Midwife	<input type="checkbox"/> RMO	<input type="checkbox"/> NUR	<input type="checkbox"/> HCA	<input type="checkbox"/> other	
<b>Surname</b>				<b>First name</b>			
<b>Email Address</b>							
<b>After hours: Mobile</b>				<b>Other</b>			
<b>NZMC#</b>				<b>CPN</b>			
<b>Smear Taker #</b>				<b>Start</b>			

### Practice Information (please use block letters)

Company  
Name

<b>Practice Name</b>				<b>HPI Facility</b>		
<b>ID DHB region</b>				<b>Phone</b>		
<b>Main type of work</b>	<input type="checkbox"/> General Practice	<input type="checkbox"/> Specialist Practice	Other: _____			
<b>Phone</b>						
	<input type="checkbox"/> HL7/Healthlink			<input type="checkbox"/> email		
<b>Preferred results delivery (tick)</b>				<input type="checkbox"/> All Results	<input type="checkbox"/> Urgent only	
	EDI: _____			Email Address: _____		
<b>Practice Manager/ Main Contact Name:</b>				<b>Practice Manager/ Main Contact Email:</b>		

### Physical Communications (Please use block letters)

	<b>Postal Address (NZ Post format)</b>	<b>For couriers (if different)</b>
<b>Street Address</b>		
<b>Suburb</b>		
<b>City</b>		
<b>Post code</b>		
<b>Courier pick and drop off instructions:</b>		

☐ I would like to receive electronic clinical information and updates from Awanui Labs

☐ I confirm that all information contained in this form is correct

**Privacy Statement** Awanui Labs Wellington is a division of Healthscope collects this information to facilitate the sending of laboratory results and related health information. Awanui Labs Wellington will also share this information with other organisations within the health sector for clinical purposes.

**Requested By:**

**Signature of Requestor:**

**Date:**

**Return completed form to email address:** [hbay@awanuilabs.co.nz](mailto:hbay@awanuilabs.co.nz)