NOTICE OF POTENTIALLY MEDICALLY DEPENDENT CUSTOMER

Patient Details

Name

Date of Birth
/ /

Email Address

Home Phone
( )

Mobile Phone
( )

Work Phone
( )

Full Physical Address Where the Patient Currently Resides

Caregiver's or Emergency Contact's Details

Name

Home Phone
( )

Email Address

Mobile Phone
( )

Work Phone
( )

Account Holder Details (if different from above)

Name

Home Phone
( )

Email Address

Mobile Phone
( )

Account Number (can be found on the residence's electricity bill)

Work Phone
( )

ICP Number (can be found on the residence's electricity bill)

Consent

You agree that we may use any information you provide to us for the purposes of carrying out our responsibilities to assit you, including discussing your information and electricity supply with Work and Income New Zealand, District Health Boards, lines companies, private health practitioners or any other social agency, budget advisor, civil defence organisation or service provider as we consider reasonably necessary.

Patient and/or Caregiver signature

Date / /

MDF08082018V1

Confirmation of Patient's Situation

I certify that:

With NHI number:

is:

☐ **Medically Dependent:** a customer who is dependent on mains electricity for critical medical support, and that loss of electricity may result in loss of life, or serious harm.

☐ **Vulnerable:** a customer who needs power because the loss of electricity may present a clear threat to health or well-being, for reasons of age, health or disability, or because of severe financial insecurity (whether temporary or permanent).

I also certify that the patient listed above has been provided knowledge, training, and support on:

(a) how to use the critical electrical medical equipment; and

(b) has a complete and tailored emergency plan for managing their condition, and medical equipment for when the supply of electricity is interrupted, whether that be for a short time, or a number of days.

Medical Condition(s)*

Type of critical medical equipment requiring a continuous supply of electricity**

Duration for which the equipment will be required

☐ Permanently

☐ Temporarily Equipment needed until: / /

Equipment reference number:

* The medical condition(s) must require critical medical support which is defined as support which, in the opinion of a DHB, private hospital or GP, is required to prevent loss of life or serious harm.

** Critical medical equipment is defined as any electrical equipment supplied or prescribed by a DHB, private hospital or GP, which requires maing electricity to provide critical medical support to a person, to support either the critical medical equipment or the treatment regime.

Name of DHB/private hospital/medical centre

Name of the healthcare practitioner/GP treating the patient

Contact Email Address of the Signatory

Contact Number of the Signatory

( )

Signature

If you wish to add additional notes or information, please attach to this form, or write details below.

Please send a copy of this completed form to YES Power via **email:** support@yespower.nz; or via **post:** PO Box 1168, Christchurch, 8013
If you have any questions regarding this form, please don't hesitate to contact us on 0800 937 769 or email; support@yespower.nz

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