**Notice of Potential Medically Dependent Consumer (MDC) Status**

**(HP notice)**

**To the Patient**

Please pass this form onto your gas provider.

**PART A - PATIENT DETAILS**

Patient’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s contact phone number(s):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(h) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(m) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(w)

Caregiver’s contact phone number(s) – *if different from patient’s*:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(h) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(m) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(w)

Full physical address (*PO Box or RD is not acceptable*) where the patient will reside on

discharge (Residence):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name(s) of gas account holder(s) at residence where the patient will reside on discharge:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact phone number(s) of gas account holder(s):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(h) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(m) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(w)

Residence’s gas ICP number (*this can be found on the residence’s gas bill – usually up to [15] characters*): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Residence’s gas account number (*this can be found on the residence’s gas bill*):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Consent:** - As the recipient of this medical equipment and a potentially medically dependent consumer, I consent to the information on this form and information on the future status of my dependence on the medical equipment to be shared between the health practitioner(s), gas retailer(s), distributors and metering service providers and/or the gas account holder for the domestic residence where I will be residing, for the purpose of ensuring that the gas retailer, gas distributor and metering service provider is informed of my medical dependence on gas equipment and my status as a medically dependent gas consumer. The gas retailer may use this information to identify residences where gas disconnection, for whatever reason, may have significant consequences.

Patient signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

and/or

Caregiver signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PART B - CONFIRMATION THAT GAS IS REQUIRED**

I certify that \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (patient’s name) with NHI number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ is:

* + 1. using natural gas or LPG dependent critical medical equipment (CGME); and
    2. at some point in the future may be dependent on the CGME to the extent that disconnection may result in loss of life or serious harm. (If so, the patient is a potentially medically dependent consumer of gas1.)

I also certify that the patient listed above has been provided knowledge, training and support, in accordance with appropriate clinical practice:

* + 1. for the use of the CGME; and
    2. what to do in an emergency, including when the supply of gas may be interrupted for any reason.

Where:

* + 1. Critical medical support 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; and
    2. CGME is defined as any equipment supplied or prescribed by a DHB, private hospital or GP, which requires natural gas or LPG to provide critical medical support to a person, and includes other gas-fuelled equipment needed to support either the CGME or the critical treatment regime (e.g., gas-fuelled space heating, water heating or refrigeration, where the same is needed to support a critical care treatment regime).

**Note**: The patient’s gas retailer may seek advice on the patient's status as a MDC if at any point in the future the patient faces disconnection.

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of DHB/private hospital/GP:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of the health practitioner treating the patient (including designation):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of the health practitioner treating the patient:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

OR

Name of another health practitioner, signing on behalf of the health practitioner treating the patient (including designation):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact number and/or email address of signatory:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Disclaimer:** The DHB/private hospital/GP/issuer of this Notice of Potential MDC Status on behalf of the patient, takes no responsibility for any debts incurred by the patient in relation to transactions or arrangements entered into by the patient with the gas retailer.

**ADDITIONAL:**

***Notice of Potential Medically Dependent Consumer Status* (Notice of Potential MDC Status)**

The Notice of Potential MDC Status has 2 parts:

**Part A** – to be completed by the patient/caregiver.

The DHBs, private hospitals and GPs can assist retailers by checking that the patient/caregiver:

* has filled in as much of the form as possible as this will assist his/her retailer to identify the correct account. Specifically, providing a residential address (not a PO Box or RD number), and recording the names of any of the household members who may be the account holder, will be particularly useful;
* understands and has signed the consent portion of the form; and
* understands the importance of:
  + completing the Notice of Potential MDC Status; and
  + giving the Notice of Potential MDC Status to the patient’s retailer.

**Part B** – to be completed by a representative of the DHB, private hospital or GP, and signed by the health practitioner treating the patient (or by another health practitioner signing on behalf of the health practitioner treating the patient).

DHBs, private hospitals and GPs should check that the patient/caregiver has been informed of all relevant aspects of using the CGME and any gas-fuelled equipment needed to support either the CGME or the critical treatment regime, including:

* what to do in the case of planned or unplanned gas outages; and
* information on the likely costs associated with operating the CGME and any gas-fuelled equipment needed to support either the CGME or the critical treatment regime and, if appropriate, advising the patient/caregiver that financial assistance may be available from Work and Income.

DHBs, private hospitals and GPs should also ensure that patients are well enough or with sufficient support to effectively communicate with their retailer when discharged from the hospital with CGME.