

FOR ICI USE

Application number	
Client number	
Date received	/ /



# MEDICAL AND CHEST X-RAY FORM

## SECTION A: GENERAL INFORMATION AND PERSONAL DETAILS

### Who can complete this certificate?

In countries where Immigration Cook Islands has an approved list of Panel Doctors and Radiologists this certificate must be completed by a listed medical practitioner and a radiologist. Please see our website: [www.mfai.gov.ck](http://www.mfai.gov.ck) for a list of Panel Doctors near you. If you are in a country where there are no Panel Doctors, a registered medical practitioner, preferably your own General Practitioner, can complete this certificate.

### What to bring to the medical examination

- Your valid passport for identification.
- Any spectacles or contact lenses you may wear.
- Any existing specialist reports, where you have a known medical condition.
- Details of any prescription medicines you are currently taking.
- Three recent passport photos (less than 6 months old).

### Children

All applicants including children and newborn babies are required to undergo a medical examination and have a medical certificate submitted as part of the application process.

- Children under 11 are not required to undergo a chest X-ray.
- Children under 15 are not usually required to undergo the standard blood tests.
- Children under 16 must be accompanied by a parent or guardian for the medical examination.

### Your responsibilities

- The applicant must pay for the examination, the chest X-ray, laboratory tests, and any specialist reports which are required.
- You must tell the truth. Any false statement on this form may result in the application being declined, any visa or permit issued being cancelled and the applicant being required to leave Cook Islands.

### What happens next?

You are required to submit this completed form including chest X-ray and laboratory results with your application for a visa or permit. The medical certificate will not be accepted more than three months after the medical examiner has signed the declaration. Immigration Cook Islands may follow-up your submission with a request for further information in the form of specialist reports or further tests.

### Instructions for Section A:

- **To be completed by the person being examined before having the medical examination.**
- Please use a black pen and write neatly in English using BLOCK LETTERS.
- Illegible forms will be returned for clarification.
- Please tick or fill in all boxes.

### Applicant:

Please attach one recent passport photograph in the space provided.



### Medical Examiner (or staff)

Valid photographic identification sighted? (e.g. passport)   
 Medical Examiner to certify identity by placing signature and date across photograph without obscuring the likeness of the person.

#### A1 Passport number

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#### A2 Your full name (as it appears in your passport)

Surname or family name

First or given names

Other names you are known by

#### A3 Full home address

  
  


#### A4 Daytime telephone number

 ( COUNTRY CODE ) ( AREA CODE )

#### A5 Email address

#### A6 Gender Male Female

#### A7 Date of birth DAY / MONTH / YEAR

#### A8 Country of birth

#### A9 Country of citizenship



**B6** If you are on medication and/or undergoing treatment, please list all medication and/or treatment. (\*Examples shown).

Drug name and/or treatment	Diagnosis	Dose	Quantity	Frequency	How long
*Aspirin		100mg	2	Daily	10 years
*Physiotherapy		-	1	Weekly	6 months

**If yes please provide details.**

**B7** Do you smoke or have you ever smoked cigarettes?

No  Yes  >

• If yes, how many per day? >

• For how many years? >

• If you have stopped, how many years ago did you stop? >

• Calculate your pack year history (packs of 20 cigarettes per day) x (number of years smoked) >

**B8** Do you drink alcohol?

No  Yes  >

• If yes, what do you drink? >

What number of drinks per week? >

**B9** Have you ever been addicted to a drug or taken drugs illegally?

No  Yes  >

**Do you have or have you ever had:**

**If yes, please provide details, including date of diagnosis and any treatment received.**

**B10** Tuberculosis (TB), an abnormal chest X-ray, chronic cough, coughed up blood, or had close contact with a person with TB?

No  Yes  >

**B11** An infectious or communicable disease lasting more than 2 weeks? e.g. typhoid, hepatitis, jaundice, rheumatic fever, HIV, AIDS or AIDS-related conditions.

No  Yes  >

**B12** High blood pressure, heart trouble, or chest pain?

No  Yes  >



Medical Examiner's initials

**For females only: have or have you ever had:**

**B27** Any reproductive system disorders, including abnormal cervical smears? No  Yes  >


**B28** What was the date of your last menstrual period? >

DAY	/	MONTH	/	YEAR
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**B29** Are you pregnant? No  Yes

If yes, expected date of delivery? >

DAY	/	MONTH	/	YEAR
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**B30 Family history of person being examined.**

Please complete the tables below detailing relationship, age and state of health of your parents, brothers and sisters. If any are deceased, please specify the age at death and cause of death. (If there is not enough space, please attach an additional sheet of paper and have this initialled by the Medical Examiner.)

Relationship (e.g. father, sister)	Age	State of health (if not good, please state reason)	Cause of death if deceased (please provide full details)	Age at death

Medical Examiner's comment (if any) on applicant's medical history:


## SECTION C: DECLARATION OF PERSON HAVING MEDICAL EXAMINATION

### Instructions for Section C:

- This declaration must be signed and dated by the person being examined in the presence of the Medical Examiner.

- A parent or guardian must sign on behalf of a child under 16 years of age.
- Please read carefully before signing:

I certify that:

- I understand the notes and questions in sections A and B of this certificate and I declare the information given about me is true, correct, and complete.
  - I understand that this declaration also applies to the chest X-ray and laboratory test sections.
  - I declare I will inform Immigration Cook Islands of any relevant fact or any change of circumstance that may affect the decision on my application for a permit or visa due to my health circumstances.
  - I authorise Immigration Cook Islands to make any enquiries it deems necessary in respect of the information provided on this certificate and to share this information with other Government agencies (including overseas agencies) to the extent necessary to make decisions about my immigration status.
  - I authorise Immigration Cook Islands to provide information about my state of health to any Cook Islands health service agency.
- I authorise any Cook Islands health service agency to provide information about my state of health to Immigration Cook Islands.
  - I undertake to pay the fees for this medical examination including chest X-ray and laboratory tests and I also agree that I or my child will undergo, at my expense, any further medical examination(s) that may be required by Immigration Cook Islands in respect of the immigration application.
  - I agree that the Medical Examiner, the radiologist and the laboratory who complete this certificate may release to Immigration Cook Islands, or any Medical Assessor employed by them, any information acquired with regard to the health of myself or my child.
  - I understand that if I make any false statements, or provide any false or misleading information or have changed or altered this certificate in any way, my application may be declined, or my visa or permit may be revoked, and that I may be committing an offence and be liable to prosecution and imprisonment.

### Signature of person being examined

(or parent/guardian)

Date

Full name of parent or guardian

Relationship to person being examined

### Declaration of person assisting:

I certify that I have assisted in the completion of this form at the request of the applicant and that the applicant understood the content of the form(s) and agreed that the information provided is correct before signing the declaration.

### Signature of person assisting applicant

(if applicable)

### Name of person assisting

Date

### Signature of Medical Examiner

### Name of Medical Examiner

Date

## PRIVACY

- The information about you on this certificate is collected to help determine your eligibility for a visa or permit.
  - You will, if you come to the Cook Islands, have the rights provided under the Official Information Act 2008 to access personal information about you held by Immigration Cook Islands, and to ask for any of it to be corrected if you think that is necessary.
  - The main recipient of the information is Immigration Cook Islands, but the information may also be shared with other government agencies which are lawfully entitled to it.
- The address of Immigration Cook Islands is PO Box 105, Avarua, Rarotonga, Cook Islands.
  - The supply of the information is voluntary, but if you do not supply it then your application is likely to be declined.
  - You can get more information and advice from:
    - Cook Islands diplomatic and consular offices.
    - The Immigration Cook Islands website at [www.mfai.gov.ck](http://www.mfai.gov.ck).

## SECTION D: MEDICAL EXAMINATION AND FINDINGS

### Instructions for Section D:

- **This section is to be completed by the Medical Examiner. Questions marked with an asterisk\* may be completed by a delegated staff member.**
- All questions must be answered.
- Where abnormalities are indicated, please provide all the relevant details in the space provided and attach any existing specialist reports.
- If there isn't enough space, attach a separate sheet. All attached sheets must be initialled by medical examiner.
- Further information for Medical Examiners can be found at <http://www.immigration.govt.nz/medicalhandbook/>

- Was a chaperone present during the examination? Yes  No  Declined
  - Was an interpreter present during the examination? Yes  No  Declined
- If yes, please provide name and the relationship to person being examined.

### D1 Date of examination

DAY	/	MONTH	/	YEAR
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### D2 BMI\*

In light weight clothing and stockinged feet:

If BMI > 35 in adults or > 97th percentile for applicants aged 15-19 years of age, or waist circumference of females ≥ 88cm, males ≥ 102cm, arrange and attach fasting lipids and fasting glucose tests. (Refer to the Handbook for Medical Examiners for further information)

Weight (kg)

Height (cm)

Waist circumference (cm)  
(for applicants 20 years and over)

BMI (Weight (kg) / (Height (m)<sup>2</sup>)  
(for applicants 15 years and over)

### D3 Head circumference\* for children under 3 years (cm)

### D4 Vision

- Visual Acuity\*:

Uncorrected Left  Right

Corrected Left  Right

- Any abnormalities of fundal examination?

No  Yes  >

### D5 Cardiovascular system

- **Blood pressure\***

(not required for children under 15 years of age)

Where repeat readings after rest exceed the following limits, arrange fasting lipids and fasting glucose tests.

- 40 years of age or less – 140/90 mmHg
- 41-64 years – 150/90 mmHg
- 65 or more years 160/90 mmHg

 / 

systolic diastolic

 / 

systolic diastolic

 / 

systolic diastolic

- **Heart** Pulse rate

Rhythm

Murmur No  Yes  >

- Peripheral pulses (any absent)? No  Yes  >

- Any bruits in neck or abdomen? No  Yes  >

- Any other abnormality? No  Yes  >





## SECTION E: URINALYSIS AND BLOOD TESTS

### Instructions for Section E:

- To be completed by the Medical Examiner on receipt of laboratory test results and urinalysis.
- Urinalysis may be completed via dipstick (by Medical Examiner) or via laboratory. Where dipstick results return abnormalities attach full laboratory urinalysis.
- Urinalysis is required for all persons (except children under five years of age).
- A child under five years of age should have urinalysis if clinically indicated e.g. a history of kidney disease or recent tonsillitis.
- The testing of females must not occur during menstruation.
- Tests for HIV, Hepatitis B, syphilis screening, liver function, full blood count and serum creatinine are compulsory for all applicants 15 years of age and over or where clinically indicated.
- Medical Examiner to sign and attach all test results.

### E1 Urinalysis results

Date:  /  /

Dipstick  Laboratory

Protein Negative  Positive  >

Sugar Negative  Positive  >

Blood Negative  Positive  >

Details if appropriate.


If tested at a later date:  /  /

Protein Negative  Positive  >

Sugar Negative  Positive  >

Blood Negative  Positive  >


### E2 Blood test results

#### Standard tests

#### Results

HIV Negative  Positive  >

If the initial test is positive, please repeat and perform Western Blot.

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Hepatitis B antigen Negative  Positive  >

Syphilis Negative  Positive  >

Liver Function Test Normal  Abnormal  >

Full Blood Count Normal  Abnormal  >

Serum Creatinine Normal  Abnormal  >


#### Discretionary tests

Normal  Abnormal  >

Hepatitis C Normal  Abnormal  >

Fasting lipids Normal  Abnormal  >

Fasting glucose Normal  Abnormal  >

HBA1c Normal  Abnormal  >

Creatinine/MicroAlbumin Normal  Abnormal  >

Faeces cultures Normal  Abnormal  >




## SECTION G: MEDICAL EXAMINER'S DECLARATION

### Instructions for Section G:

- **This declaration must be signed and dated by the Medical Examiner who was responsible for this examination.**
- This declaration must be signed after the Medical Examiner has sighted and considered the chest X-ray certificate and all medical test results.
- **Please read carefully before signing:**

I certify that:

- This person has been examined by me or staff under my supervision and their identification in terms of papers, photographs and appearance has been confirmed.
- The statements my staff and I have made in answer to all the questions are true, correct and complete to the best of my knowledge.
- All tests, investigations and reports I have considered are signed by me and securely attached.

**G1** Signature of Medical Examiner

**G2** Date

### Medical Examiner's Details (please print)

**G3** Full name

**G4** MCNZ number for New Zealand practitioners

**G5** Place of examination  
(city/state and country)

**G6** Postal address

  
  

**G7** Daytime telephone number

**G8** Email address

**G9** Would you like Immigration Cook Islands to contact you about this examination?

No  Yes



# LABORATORY REFERRAL FORM

## SECTION H: INSTRUCTIONS FOR MEDICAL EXAMINER AND LABORATORY

**Instructions for Medical Examiner:**

- Please complete your contact details.
- Please confirm which tests are required for this applicant.
- HIV, Hep B, Syphilis, LFT, FBC and Serum creatinine tests are compulsory for all applicants 15 years of age and over or where clinically indicated.
- Hepatitis C Antibody test is required where clinically indicated.

- Fasting glucose and fasting lipids are required if indicated by BMI, waist circumference or blood pressure (at questions D2 and D5).
- HBA1c and Creatinine MicroAlbumin Ratio tests are required for diabetics.
- Where other conditions are identified refer to Handbook for Medical Examiners.

**Instructions for Laboratory:**

- Please return this form and results to the requesting doctor.

**Applicant's Details** (please print)

**H1** Applicant's full name

**H2** Applicant's date of birth

**H3** NHI number (NZ)

**H4** Gender Male  Female

**H5** Medical Examiner's Laboratory Reference Number (if applicable)

## LABORATORY TESTS REQUIRED

Standard tests		Discretionary tests	
HIV	<input type="checkbox"/>	Urinalysis	<input type="checkbox"/>
Hepatitis B surface antigen	<input type="checkbox"/>	Hepatitis C Antibody	<input type="checkbox"/>
Syphilis screening	<input type="checkbox"/>	Fasting lipids	<input type="checkbox"/>
Liver function tests	<input type="checkbox"/>	Fasting glucose	<input type="checkbox"/>
Full blood count	<input type="checkbox"/>	HBA1c	<input type="checkbox"/>
Serum Creatinine	<input type="checkbox"/>	Creatinine MicroAlbumin Ratio	<input type="checkbox"/>
		Faeces culture	<input type="checkbox"/>
			<input type="checkbox"/>
			<input type="checkbox"/>
			<input type="checkbox"/>

**H6** Signature of Medical Examiner

**H7** Date

**Medical Examiner's Details**

**H8** Full name

**H6** Postal address

## SECTION I: CONFIRMATION OF IDENTITY AND DECLARATION

**Instructions for Applicant:**

- Please attach one recent passport photograph in the space provided.
- Please complete I1 – I6 before your examination.
- Please present this form when having blood taken for testing.
- **The declaration below must be completed and signed in front of the person taking blood.**



**Person taking blood:**

Valid photographic identification sighted? (e.g. passport)   
 Person taking blood to certify identity by placing signature and date across photograph without obscuring the likeness of the person.

**Applicant**

**I1** Passport number

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

**I2** Your full name (as it appears in your passport)

Surname or family name

First or given names

Name you are known by

**I3** Gender    Male  Female

**I4** Date of birth    DAY / MONTH / YEAR

DAY	/	MONTH	/	YEAR
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**I5** Country of Birth

**I6** Country of Citizenship

**Applicant's Declaration:**

- I certify that I have read and understood the declaration at section C on page 6.
- I understand that the declaration at that section also applies to the laboratory tests.

**Signature of applicant**

(or parent/guardian)

Date

DAY	/	MONTH	/	YEAR
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Full name of parent or guardian

Relationship to person being examined

**Declaration of person assisting:**

I certify that I have assisted in the completion of this form at the request of the applicant and that the applicant understood the content of the form(s) and agreed that the information provided is correct before signing the declaration.

**Signature of person assisting applicant**

(if applicable)

**Name of person assisting**

Date

DAY	/	MONTH	/	YEAR
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**Declaration of person taking blood:**

I certify I have confirmed the applicant's identity in terms of papers, photographs and appearance.

**Signature of person taking blood**

**Name of person taking blood**



# CHEST X-RAY SECTION

## SECTION J: GENERAL INFORMATION AND CONFIRMATION OF IDENTITY

**Instructions for Applicant:**

- Please attach one recent passport photograph in the space provided.
- Please complete J1 – J6 before your examination.
- Please take this form when presenting for your chest X-ray
- **The declaration below must be completed and signed in front of the radiographer**

**Instructions for Radiographer:**

- Valid photographic identification sighted? (e.g. passport)
- Radiographer to certify identity by placing signature and date across photograph without obscuring the likeness of the person.*



**Applicant**

**J1 Your full name** (as it appears in your passport)

Surname or family name

First or given names

Other names you are known by

**J2 Gender** Male  Female

**Applicant's Declaration:**

- I certify that I have read and understood the declaration at Section C on page 6.
- I understand that the declaration at that section also applies to the chest X-ray section

**Signature of applicant**

(or parent/guardian)

Date

Full name of parent or guardian

Relationship to person being examined

**J3 Passport number**

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**J4 Date of birth** DAY / MONTH / YEAR

**J5 Country of Birth**

**J6 Country of Citizenship**

**J7 Medical Examiner's name**



DAY / MONTH / YEAR



**Declaration of person assisting:**

I certify that I have assisted in the completion of this form at the request of the applicant and that the applicant understood the content of the form(s) and agreed that the information provided is correct before signing the declaration.

**Signature of person assisting applicant (if applicable)**

**Full name of person assisting**

Date

DAY / MONTH / YEAR

**Declaration of Radiographer or Examining Radiologist:**

I certify I have confirmed the applicant's identity in terms of papers, photographs and appearance.

**Signature of Radiographer or Examining Radiologist**

**Name of Radiographer or Examining Radiologist**

## SECTION K: RESULTS OF CHEST X-RAY FILM EXAMINATION

### Instructions for Section K:

- **This section is to be completed in full by the radiologist.**
- All questions must be answered.
- Please answer all questions in English.
- Please print or write clearly. Illegible forms will be returned for clarification. Please use a black pen.
- Where abnormalities are present, the radiologist must provide details and comments in the space provided.
- Where abnormalities are present, the X-ray film must accompany the certificate.
- The radiologist's report must be attached to this certificate and both returned to the Medical Examiner.

**K1** Notes to Radiologist (if applicable)

**If abnormalities, please provide details.**

- |  |                                 |                                   |   |
|--|---------------------------------|-----------------------------------|---|
| <b>K2 Skeleton and soft tissue</b>               | Normal <input type="checkbox"/> | Abnormal <input type="checkbox"/> | > |
| <b>K3 Cardiac Shadow</b>                         | Normal <input type="checkbox"/> | Abnormal <input type="checkbox"/> | > |
| <b>K4 Hilar and Lymphatic glands</b>             | Normal <input type="checkbox"/> | Abnormal <input type="checkbox"/> | > |
| <b>K5 Hemidiaphragms and costophrenic angles</b> | Normal <input type="checkbox"/> | Abnormal <input type="checkbox"/> | > |
| <b>K6 Lung fields</b>                            | Normal <input type="checkbox"/> | Abnormal <input type="checkbox"/> | > |
| <b>K7 Evidence of TB</b>                         | No <input type="checkbox"/>     | Yes <input type="checkbox"/>      | > |
| <b>K8 Evidence of old, healed TB</b>             | No <input type="checkbox"/>     | Yes <input type="checkbox"/>      | > |
| <b>K9 Evidence suspicious of active TB</b>       | No <input type="checkbox"/>     | Yes <input type="checkbox"/>      | > |
| <b>K10 Details of other abnormalities</b>        |                                 |                                   | > |


## SECTION L: RADIOLOGIST'S DECLARATION

### Instructions for Section L:

- **This declaration must be signed and dated by the radiologist who examined the chest X-ray film.**
- **Please read carefully before signing:**

I certify that:

- the statements my staff and I have made in answer to all the questions are true, correct and complete to the best of my knowledge.

**L1** Signature of Radiologist

**L2** Date

DAY	/	MONTH	/	YEAR
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**Radiologist's Details** (please print)

**L3** Full name

**L4** MCNZ number for Cook Islands practitioners

**L5** Place of examination (city/state and country)

**L6** Postal address

**L7** Daytime telephone number

( COUNTRY CODE )	(	AREA CODE	)
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**L8** Email address