DECLARATION OF COMPETENCE TO RECEIVE POAC/POADMS REFERRALS FOR ABNORMAL UTERINE BLEEDING (AUB) AND/OR PELVIC PROLAPSE (PP) FROM OTHER PRACTICES

Objective

To ensure GPs who accept POAC/POADMS referrals for AUB and/or PP management from other practices provide a culturally and clinically competent service.

Personal Details

Note these details will be collected and held internally by the POAC/POADMS teams to capture geographic coverage of practices who are accepting referrals from other practices. Information may be provided to Health New Zealand – Te Whatu Ora for reporting purposes.

Detail	Provide Information
Full Name	
Workplace	
Workplace address	
PHO	
Designation/role	
Ethnicity	
Gender	
Registration number	
Email	
Mobile number	

Required	
☐	I have assessed the need in my workplace and can perform sufficient procedures per year to maintain my clinical competence.
☐	My cultural competency training is up to date
Tick all that apply	
☐	**AUB** I have completed the AUB modules on https://koawatealearn.co.nz/course/view.php?id=13306 https://www.healthlearn.ac.nz/course/view.php?id=4144 or equivalent training aligned with the NZ National guideline on AUB 2025
☐	I have completed Mirena insertion training that meets the NZ National Guideline for LARC training https://www.health.govt.nz/system/files/2022-06/larc-health-practitioner-training-fin-jun2022.pdf
☐	**Pelvic Prolapse** I have completed the Pelvic pessary modules on https://koawatealearn.co.nz/course/view.php?id=13306 https://www.healthlearn.ac.nz/course/view.php?id=4144 or equivalent training
☐	I have the clinical skills required to competently insert pessaries

Referrals

☐	I am willing to accept POAC/POADMS referrals from outside my practice *Note this is not a requirement to access POAC/POADMS funding for delivery of AUB/PP management in your own practice.* Contact Details for receiving referrals: Practice Email: _____ Practice Phone Number: _____
☐	I consent to having my practice name published on the POAC/POADMS website

Declaration

I confirm that the information provided in this application is accurate and complete.

- Name:
- Date:
- Signature: _____

Please submit your completed application to:

primaryops@mahitahihauora.co.nz (Northland)

claims@poac.co.nz (Metro Auckland)