

South Coast Recovery Centre

Admission Application

Residents Personal Information:

- Title: _____
- Surname: _____
- Full Names: _____
- Age: _____ ID Number: _____
- Residential Address:

- Postal Address:

- Contact Numbers: Home _____
Work _____
Cell _____
Fax _____
Email _____
- Hobbies/ Interests:

- Marital status: Single / Married / Divorced
- Number of Children: _____ Ages: _____
- Religion and Church: _____

Residents Employment Details: (If unemployed, please provide previous employment):

- Employer: _____

- Occupation: _____
- Period: From: _____ To: _____

Residents Tertiary Education, Qualifications, Courses Attended :

Skills: (e.g. computers, welding, sewing, woodwork...)

Allergies:

Details of any Addictions within the Family:

Previous Rehabilitation Attended (where & when):

Details of any Psychological treatment and/or Diagnosis:

Current Medication (Please note: any medication must be accompanied by a script) :

Referred by: _____

DETAILS OF USAGE

IT IS IMPORTANT TO CORRECTLY DETAIL THE NARCOTICS USED, THEIR FREQUENCY AND THE AMOUNT OF MONEY SPENT. (THE APPLICANT IS ABLE TO COMMUNICATE THIS TELEPHONICALLY, DIRECTLY TO ONE OF OUR REPRESENTATIVES)

Details of Responsible Person/Sponsor (The person Responsible for paying the Account):

- Mr / Mrs / Miss
- Surname: _____
- Full names: _____
- ID Number: _____
- Residential Address:

- Postal Address:

- Contact Numbers: Home _____
Work _____
Cell _____
Fax _____
Email _____

Method of Payment: _____

Details of Next of Kin: _____

Any other Relevant Information: (e.g. Court cases):

Signed on this day ____ of _____ 200__ in/at

Resident

Witness

Sponsor/Responsible Person

Witness

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Personal Medical Information

Please complete all the information needed on this form, to be used in the event of routine and medical emergency. Should the resident be on medical aid, please supply a copy of their medical aid card. Please be advised that we are contracted out of medical aid. As such, all accounts need to be settled directly. We will however provide you with the necessary documentation to claim back from your medical aid.

Full Names of resident:	
Identity Number:	
Current Medication:	
Medical Condition/ Allergies: e.g. Diabetes, Bi-polar.	
Name and Tel Number of Family Doctor/GP:	
Name of Medical Aid:	
Medical Aid Number:	
Members Name:	
Medical Aid Plan:	Comprehensive Plan / Hospital Plan / Other
Full Names of Responsible Person:	
Identity Number:	
Physical Address:	
Postal Address:	
Telephone Numbers	(Cell) (W) (H)
Name of Next of Kin:	
Telephone Number:	