ADMISSION FORM

Please complete the following fields and sign each page

DATE Y Y M M D D

APPLICANT INFORMATION			
PERSONAL PARTICULARS			
Mr/Mrs/Miss/Ms/Dr:		Surname:	
First name(s):		ID/passport no.:	
Dependants:		Citizenship:	
Age:		First language:	
Race:		Marital status:	
Other languages:		Spouse address:	
Spouse name:			
Spouse contact no.:			Code:
CONTACT DETAILS			
Cell no.:		Physical address:	
Tel work:			
Tel home:			Code:
Fax no.:		Postal address:	
Email address:			
Next of kin name:			Code:
Next of kin contact:		Relationship:	
PARENT / SPONSOR DETAILS			
Mr/Mrs/Miss/Ms/Dr:		Surname:	
First name(s):		ID/passport no.:	
Language:		Relationship:	
Cell no.:		Tel work:	
Tel home:		Email address:	
Physical address:		Postal address:	
	Code:		Code:
OCCUPATION DETAILS			
Employment status:		Years employed:	
Profession:		Position:	
Employer name:		Employer address:	
Employer contact:			
Website:			Code:
LEGAL INFORMATION			
Criminal record:		Details:	
Pending case(s):		Charge details:	
Court date:		District:	
Attorney name:		Attorney contact:	
OTHER INFORMATION			
Hobbies:			
Interests:			
How did you hear about			

us?	

Parent/sponsor signature:_____ Applicant signature:_____

Admission Form continued

Present physical health condition:	(eg. poor/average/good/excellent)	Present injuries on admittance:	
Present psychological status:		Comment:	
Any chronic illness(es):		Any disabilities:	
Prescription medication **(give details)**:		Course(s) ending / repeating on:	
Period on medication:		Specialist name:	
GP name:		Specialist tel no.:	
GP address:		Specialist address:	
GP tel no.:		Specialist type:	

MEDICAL HISTORY							
Have you been tested for any of the following:	**HIV/AIDS**		date:	Other medical tests: **(provide details)**:		date:	
	TB		date:			date:	
	Syphilis		date:			date:	
	Hepatitis		date:			date:	
Serious operation(s):						date:	
						date:	
Serious illness/injuries:						date:	
						date:	
Serious illness:						date:	
						date:	
Self mutilation:						date:	
Eating disorder(s):						date:	
Suicidal ideation:						date:	
Any other medical history information:						date:	
						date:	
						date:	

Medical aid name:		Medical aid plan:	
Membership no.:		Main member:	
Dependant code:		Medical aid tel no.:	

PLEASE NOTE: the parent/sponsor is liable for any medical costs incurred for the applicant should the applicant not be on medical aid.

Parent/sponsor signature: _____ Applicant signature: _____

Admission Form continued

Please supply confidential and any other personal information which can aid counsellors.

eg. How the drug abuse of the applicant affected him/herself and their loved ones emotionally, physically, spiritually and socially.

(This information is private and confidential and will not be shared without consent of the signatories).

I declare that all information supplied herein is complete and honest. I understand that if found that any details have been omitted or supplied falsely I may be asked to leave the recovery centre and may not hold Hillview Manor liable in any way.

Signed: _____	Signed: _____
Applicant name: _____	Parent/sponsor name: _____
Date: _____	Date: _____