Harmony Retreat

Halfway House

PRE-ADMISSION / APPLICATION FORM

DETAILS OF APPLICANT

Identification Number: _____Age: _____

Surname: _____ Full Names: _____

Gender: _____ Date of birth: _____ Home Language: _____

Email Address: _____ Tel. Home: _____

Work: _____ Cell: _____

ADDICTION PROBLEM

Please give the patient's own answers to the following questions. False information may lead to discharge.

1. What substance did you use? Specify _____
2. How much did you use per day? _____
3. Have you ever thought of and / or attempted suicide? _____
4. Are you currently drinking/using too much? _____
5. Do you often drink/use for a few days continuously? _____
6. Does your drinking/use affect your family life negatively? _____
7. Does your drinking/use create problems at work? _____
8. Does your drinking/use create financial problems? _____
9. Has your drinking/use caused deterioration in your health? _____
10. Do you feel guilty about your drinking/drug use? _____
11. Do you feel your substance use has become a serious problem? _____
12. Who is responsible for your addiction? _____
13. For how long have you had an addiction problem? _____
14. Are you willing to, on a voluntary basis, do the full treatment at Harmony Retreat? _____

PREVIOUS TREATMENT FOR ADDICTION PROBLEM

NB: Please provide letters of confirmation from Treatment Centres/Clinics

CENTRE	ADMISSION DATE	DURATION OF TREATMENT	PROGRAM COMPLETED YES/NO	PERIOD SOBER AFTER TREATMENT

Postal Address:

P.O. Box 216
Greytown
3250

+27 33 417 2227

+27 84 417 2227

N.P.O. 056442

admin@harmonyretreat.org

www.harmonyretreat.co.za

P.B.O. 930053384

Has the patient been diagnosed with any psychiatric condition? If so, please provide details below.

_____

_____

Is the patient currently suffering from any medical condition, either acute or chronic that might prevent him from fully participating in the treatment program, or might endanger his well-being/life? If yes, please provide details below. (TB, Aids, High blood-pressure, disability etc)

_____

_____

_____

Is the patient currently on any prescribed chronic/psychiatric medication? If so, please provide details below, and attach a copy of the prescription.

Date	Prescribed Medication and schedule.	Prescribed By	Dosages	Script available

- Fees are R10,000 per month for the first 12 months. A fee reduction will be considered thereafter based on the patient's progress.
- Transport costs of patients from: Pietermaritzburg – R550; from Durban – R750.

Signed by (name): _____ Date:_____

Signature:_____

Please email the completed form back to:
gad@harmonyretreat.co.za