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/s 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 a 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. How long have you had an addiction problem? _____________________________
14. Are you willing to, on a voluntary basis, do the full treatment at The Agape House? __________

PREVIOUS TREATMENT FOR ADDICTION PROBLEM

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

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

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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, HIV, High blood-pressure, disability etc)

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Is the patient currently on any prescribed chronic/psychiatric medication? If so, please provide details below including Schedule 5 or above, and attach a copy of the prescription.

Date	**Prescribed Medication & Schedule of medication**	**Prescribed By**	**Dosages**	**Script available**

Does the patient have Medical Aid?   Yes / No

Please provide details.

Name of Medical Aid: ____________________________________

Main Member's Name:____________________________________

Main Member I.D. Number: ________________________________

Membership Number:_____________________________________

- **Cost of treatment : Covered by Medical Aids for the first month. Cash patients R26 000 per month**
- Transport costs of patients' collection: Pietermaritzburg R600; Durban R1000.

Signed by (name): _________________________________ **Date:**______________________

Signature:____

Please email form to: gad@harmonyretreat.co.za