A program of BADISA
P.O. BOX 515, Worcester, 6849
Tel: (023) 342-1162
Practice Number: 0470010043583 Email: opname@toevlug.org

ADULT APPLICATION FORM

*Application form can **only** be completed by a **professional person** e.g. Social Worker, Doctor, Nurse, Psychologist, Psychiatrist, Preacher etc.*

A.	**INFORMATION OF REFERENT**				
Title:		Surname:		Name:	
Occupation:					
Organisation:					
Address:			Telephone		
			Email		
Are you willing to render aftercare services to the applicant?				**YES**	**NO**
If "YES" for what period:					

If "NO", provided the information of the person who will render the **aftercare** services.

Title:		Surname:		Name:	
Occupation:					
Organisation:					
Address:			Telephone:		
			Email:		

B.	**INFORMATION OF APPLICANT**							
B1.	**IDENTIFYING INFORMATION OF APPLICANT**							
Title:		Surname:						
Name:								
Date of birth:				Age:				
Identity number:								
Gender:	Male		Female		Other			
Sexual orientation:	Hetero-sexual		Homo-sexual		Bisexual		Other	
Marriage status:								
Home language:			Other languages:					
Religion:	Christian		Muslim		None		Other	
Church affiliation:								
Highest scholastic qualification:			Highest tertiary qualification:					

B2.	**CONTACT INFORMATION OF APPLICANT**	
Residential address:		
	Postal code:	
Contact numbers:	Home:	
	Cell:	
Email:		

B3.	OCCUPATIONAL INFORMATION OF APPLICANT

Is the applicant unemployed?	**YES**, Complete 3.1	**NO**, Complete 3.2 & 3.3

3.1	**Unemployed:** (If "YES", complete)			
How long is the applicant unemployed?				
What was the applicants previous occupation?				
Does the applicant have any sources of income?	If "YES", please indicate the sources:			
Has the applicant previously received a government subsidized bed for substance use treatment?	YES		NO	
	If "YES", please specify when and where:			

3.2	**Current occupation:** (If "NO", complete)				
Name of employer:					
Type of occupation:					
Postal address:			Telephone:		
			Email:		
Work contact person:					
Title:		Surname:		Name:	
Capacity:			Telephone:		
			Email:		

3.3	**Disclosure of information to the employer:** (If "NO", complete)

Hereby I, ...(Initials & Surname) the undersigned declare that:

- My employer is aware ☐ / unaware ☐ of my admission to Toevlug Centre.
- Any information requested by my employer/contact person at work may be provided to them ☐ / may not be provided to them ☐.

Signature ..... Date: 20.... / .... / ....

C. PAYMENT INFORMATION OF TREATMENT (Complete C1 OR C2)

C1. MEDICAL AID (NB: Attach a copy of the medical aid card to the application form)			
Name of aid		Medical aid number	
Aid option/plan		Patients aid code e.g. 01, 02 etc.	
Name & Surname of Main Member			
Email			
Postal address			
Town		Postal code	
Telephone		ID number	
PLEASE NOTE: If not paid out by the medical aid, the applicant remains responsible for settling the account.			

C2. RESPONSIBLE FOR ACCOUNT:	*(Mark your choice with an X and indicated information below)*					
	Institution		Applicant		Other person (specify)	

Institution/ Person		*(If institution/ other person, indicate the contact persons information below)*
Surname		
Name		
Relation e.g. Employer/Parent/Spouse		
Email		
Postal address		
Town		Postal code
Telephone		

Method of payment	Cash		Cheque		*Electronic	

*** PLEASE NOTE: If electronic payment, send proof of payment to accounts@toevlug.org**

Gross monthly income of applicant	R
Gross monthly income of applicant's spouse	R
Gross monthly income of applicant's parents (In cases where applicant is still dependent on parents)	R

PLEASE NOTE: Attach a copy of the most recent payslip as proof of above mentioned information

Hereby I, ...(Initials & Surname) the undersigned declare that I take full responsibility for the account.

Signature: ..... Date: 20.... / .... / ....

Bank information:
Toevlug Centre; ABSA Worcester; Branch Code: 503107; Account Number: 0440850278

D.	**SUBSTANCE USE PROBLEM**	
D1.	**Substance use questionnaire** *(Mark with an X)*	
If looked at the applicants substance use over the past 12 months, which of the following statements is considered applicable:		X
1.	Is the applicant using the substance in greater volumes or for longer periods than he/she intended to?	
2.	Does the applicant want to use less of the substance or stop but fails to do so?	
3.	Does the applicant spend a lot of time getting a hold of/using/recovering from the substance?	
4.	Does the applicant have cravings/urges to use the substance?	
5.	Does it occur that the applicant cannot fulfil his/her responsibilities towards work/home/school due to their substance use?	
6.	Does the applicant continue to use the substance even though it creates problems in their relationships?	
7.	Did the applicant give up important social/occupational/recreational activities due to his/her substance use?	
8.	Does the applicant use the substance repeatedly even though it puts them in danger?	
9.	Does the applicant continue to use even though he/she developed a physical or psychological problem that was caused by/worsen by the substance use?	
10.	Does the applicant need more of the substance to try and get the same effect? (Tolerance)	
11.	Does the applicant develop withdrawal symptoms that is relieved when they take more of the substance?	

D2.	Primary substance	Secondary substance
Type of substance		
Duration of use		
Degree/ How much		
Age of onset		

Other substances:

Other behavioural addictions: *(E.g.: Sex, Gambling, Pornography etc.)*

D3. Previous treatment			YES	NO
If "YES", complete below.				
Name of treatment centre	Admission date	Duration of treatment	Program completion	
			Yes	No
In case of uncompleted treatment, indicate reasons for early discharge:				

D4.	Disclosure of information of previous treatment

Hereby I, ...(Initials & Surname) declare that my:

- Records of my previous treatment can be provided to Toevlug ☐ / cannot be provided to Toevlug ☐ .

Signature: ..... Date: 20.... / .... / ....

D5.	Motivation						
Applicant's **motivation** for treatment	Good		Average		Poor		
Applicant's **insight** regarding damages cause by substances	Good		Average		Poor		
Comments regarding insight and motivation:							

E.	CLASHES WITH THE LAW	
Nature of transgression	Date	Sentence

Does the applicant have **court cases** pending?	YES		NO	
If "YES", describe:				
Is the applicant involved with **gangs**?	YES		NO	
Name of gang				
Duration of involvement				
Position in gang				

F.	**APPLICANTS PERSONAL CIRCUMSTANCES**

F1. Provide relevant information regarding the applicant's **childhood** years e.g. Parental home, general development, school history and family structure.

F2. Provide information regarding the applicant's current marital and family **relationships**.

F3.	Is there any of the following within the household of the applicant?		
	YES	NO	If "YES", describe whom as well as the circumstances:
Substance use			
Domestic Violence			
Trading of alcohol/drugs			
If "YES" indicate the strategy to address these circumstances:			

G.	**APPLICANTS EMOTIONAL WELLBEING**			
Has the applicant previously received **psychological** treatment?	YES		NO	
Has the applicant previously received **psychiatric** treatment?	YES		NO	

If "YES", describe why, when, medication. *(Please attach copies of discharge letters)*

Is there a history of **self-harming**?	YES		NO	
Has there been previous **suicide attempts**?	YES		NO	

If "YES", describe: (When, How, Why, Hospitalisation etc.)

H.	**PARTICIPATION IN THE PROGRAM**		
NEAREST FAMILY MEMBER/ SIGNIFICANT OTHER (Person to be contacted in case of an emergency)			
Surname:		Name:	
Relation:		Cell phone:	
		Email:	

Is the spouse/family/friend/parents of the applicant willing to **therapeutically join** the treatment program?	YES		NO	

If "YES", indicate whom:

I1.	**Declaration by Applicant**

Hereby I, ... (Initials & Surname) the undersigned declare that:

- The information provided in this report is accurate and that no information was withheld from Toevlug.

Signature: ..... Date: 20.... / .... / ....

I2.	**Declaration by Referent**

Hereby I, ...(Initials & Surname) the undersigned declare that:

- The information provided in this report is accurate as given to me by the applicant/applicants family and that no information was withheld from Toevlug.

Signature: ..... Date: 20.... / .... / ....

Registration number at Professional Board: .....

TREATMENT CONTRACT

(Take note: The applicant must read this form and sign it in the presence of the referent.)

I, the undersigned _____ (THE APPLICANT'S FULL NAME) hereby conclude the following agreement with **Toevlug Centre.**

1. I hereby consent to be **admitted** to Toevlug for at least **5 weeks** and I will undergo the required examinations and treatments, as determined by TOEVLUG'S Director.
2. **I accept:**
    A. Toevlug's **household rules** and promise to give my sincere cooperation in all regards.
    B. That the Director has the right to terminate my treatment if I do not **cooperate** fully in my treatment program.
    C. That my treatment will be terminated if I bring **alcohol/drugs/non-prescribed medication** to Toevlug, if I use it, or give it to fellow patients during my treatment period.
    D. That my treatment will be terminated if I act **verbally or physically aggressive** towards staff or fellow patients.
    E. I accept that I can be suspended if I break the household rules or if I am guilty of misconduct. I accept that I may be suspended even though I live far away from Toevlug. In such a case I will be responsible for my own discomfort and travel arrangements and I must **leave the centre within one hour of discharge**.
3. **I promise** not to bring any alcohol, drugs or non-prescribed medication onto Toevlug's premises, nor to have it fetched, nor to help someone else to obtain it. I came to Toevlug to be rehabilitated, and I will willingly cooperate in the following:
    A. I will, for everyone's interest, report to Toevlug's staff, if anybody, to my knowledge, have alcohol or drugs in their possession, use it or offer it to me or anyone else. I will tell the truth when asked about it.
    B. I willingly submit to any **drug tests** according to the practices of Toevlug.
    C. My luggage, cupboard, or other storage place will always be accessible for **inspection** by a member of the staff.
    D. I willingly submit myself to the searching of the centre, my baggage and cupboard by the **SAPS dog unit.**
    E. I undertake to pay compensation for any damages I caused to **property** of Toevlug.
4. I undertake that neither I, nor any other person, who acts on my behalf, will **sue** the staff or management of Toevlug regarding the consequences of any medical or therapeutic procedures, accident, misunderstanding or suspension due to misconduct.
5. I give my consent that my social worker/aftercare group/referent may be informed of my admission and progress at Toevlug.
6. I give permission for my social worker at Toevlug to complete and send a **discharge report** of my treatment to my referent/aftercare provider.
7. I accept full responsibility for my **account/treatment fees** that is determined by Toevlug's tariff scales. Toevlug reserves the right to make enquiries regarding my income information given on the application form. If I breach this contract I will still be held responsible for my full treatment fees/account.
8. (Only for patients receiving **subsided treatment**): I accept that if a breach this contract and do not complete my treatment duration, that was funded by the Department of Social Development, that I will be held responsible for the full treatment fees/account owed to Toevlug.
9. I understand that my **treatment fees/account,** as given, must be paid in full before admission. I understand that should my treatment program be terminated, that I will not be reimbursed for my treatment fees.
10. I accept that routine detoxification medication is included in the treatment fees/account but that I'm responsible for paying any other **medication** that is not part of routine detoxification medication. If I am currently on prescribed medication, I will bring enough medication for the treatment duration.
11. I will pay the specified fees for my partner/friend/families stay at Toevlug during their joining of the treatment program.
12. I understand that Toevlug is a **smoking free** program and that no cigarettes/matches/lighters is allowed on the premises and will be destroyed. **Non-prescribed and addictive medication** will be destroyed on admission.

I hereby declare that I have read the rules given above, and understood and accept it.

THUS AGREED AND SIGNED AT _____(PLACE) ON THE _____ DAY OF_____

20_____.

SIGNED: **_____** **_____**

APPLICANT **REFERENT**

TOEVLUG CENTRE

*This report has to be completed by a **medical practitioner**.*

1. PATIENT INFORMATION:					
Surname and Initials of the patient:					
Date of birth:					
File number:					
2. MEDICAL BACKGROUND:					
Have you treated the patient before?	YES		NO		
Does the patient have a diagnosis of **HIV/AIDS**:	YES		NO		
If "NO", when last did the patient receive an **HIV test**:					
If "YES", when was the last **viral load** and **CD4 count** tested & results thereof: *(NB: Attach a copy of the latest results)*					
If "YES", what **ARV regimen** is the patient on and when was the regimen initiated:					
Other current **chronic conditions**:					
Other current prescribed **medication**: *(NB: Attach a copy of the prescription)*					
3. PSYCHIATRIC BACKGROUND: *(Psychosis, suicide attempts, depression, DT's, medication, admissions etc.):*					
Is the patient **psychiatrically stable** for admission?	YES		NO		
4. SUBSTANCE USE HISTORY:					

5. PHYSICAL EXAMINATION:					
Blood sugar (HGT):		Weight:			
Haemoglobin (HB):		Dietary restrictions:			
Blood pressure:		Allergies:			
Pulse/Beats:		Temperature:			
Urine test:		Pregnant:	YES	NO	
Teeth:		Last menstrual cycle:			
Respiratory:		Family planning:	YES	NO	
Physical disability:		**TB Screening:** History of TB	YES	NO	
Cardiovascular:		Cough	YES	NO	
Abdominal:		Night sweats	YES	NO	
Neurological:		Unexplained weight loss	YES	NO	
Dermatological:		Close contact with a TB patient	YES	NO	
Is the patient **physically stable** for admission and detoxification?		YES		NO	

6. INFORMATION OF MEDICAL PRACTITIONER:			
Name & Surname:		Telephone:	
Qualifications:		Address:	
Practice number:		Email:	
Signature:		Date:	

Thank you for the completion of the medical report. Enquiries welcome. Telephone number: 023 342 1162

FORM 7*(Only for subsidized service users)*

APPLICATION FOR ADMISSION AS VOLUNTARY SERVICE USER TO TREATMENT CENTRE

Section 32 (1) of Prevention of and Treatment for Substance Abuse Act, 2008 (Act No. 70 of 2008)

(Regulation 45(1))

Name of treatment centre where admission is desired:

TOEVLUG CENTRE
40 NOBLE STREET
WORCESTER
6850

Particulars of voluntary service user:

Surname	
First Names	
Address	

I am fully aware of the implications of Section 32(1) of Act 70 of 2008 and undertake to abide by the rules of the above named centre			
Signed		Date	

To	**opname@toevlug.org**
From	

1. I support the application and refer the person to you for treatment
2. The voluntary service user **can/ cannot contribute** financially towards his/her residence and treatment
3. The following documents are attached:
   (a) Medical certificate
   (b) Social Report *(Application form)*
   (c) My reference number is……..

Social Worker/ Referrer:		Date	
Address:			

WHAT TO BRING ALONG FOR ADMISSION:

1	Tooth Paste, Tooth Brush, Mouth Wash (No mouth wash containing alcohol)	
2	Wash Cloth and Soap/Body wash	
3	Shampoo, Conditioner	
4	Disposable Shaving Blades (Will be kept at the medical department and not in the patients possession)	
5	Towel x 2 (One for bathroom uses and one for swimming)	
6	Roll- On (No deodorant spray allowed)	
7	Sanitary Towels (Females only)	
8	Comb/Hair Brush	
9	Underwear and Socks	
10	Everyday Clothes	
11	Sleepwear	
12	Sport Clothes and Trainers (For use in gym and during sport activities)	
13	A Set of Neat Clothes (For church services and discharge ceremony)	
14	Swimwear (No bikini's for females)	
15	Washing Powder/Washing Soap and Pegs	
16	Writing Pad/Writing Book, Stationary (A5 notebook and pen provided on day of admission)	
17	Bible/Quran	
18	**Lock and Key** for cupboard	
19	Music Instruments (At own preference and own risk)	
20	ID Book/Card	
21	Medical Aid Card or Clinic Card	
22	**Prescription Medication**; enough for 5 weeks. Diabetic patients have to bring their own sugar level test machine and test strips.	
23	**Pocket Money** (Paid in once on day of admission- Electronic payment)	
24	Headlamp / Flash light	
25	Mosquito repellent	
26	Fan (At own preference and risk)	
27	Clock radio (At own preference and risk)	

NOT ALLOWED:	VERY IMPORTANT:
• **Food/Sweets/Confectionaries.** • CD's, DVD's, MP3 players or large radio's. Only clock radios are allowed. • Alcohol mouth wash. • Deodorant spray. • **Cigarettes/ Lighters/Matches/Vapes.** • No clothing and items with drug/alcohol/gang/satanic signs. • No Cell phones. • No Cameras. • No Computers/laptops. • No memory sticks. • Pornography/ Sexual material e.g. Condoms. • Tattoo machines or equipment. • Earing's for men. • Sharp objects/ weapons.	• **No town visits** are allowed. All financial arrangement e.g. Transfer of money/receiving of salary/withdrawal of grants etc. have to be finalised/arranged before admission. • **Pocket money** budget have to be drawn up before admission. Pocket money have to be paid in once on admission. Patient will have access to a shop twice a week where they will be able to buy sweets/ confectionaries/toiletries. Toevlug is a **cash free program**. • **Toevlug is a smoking free program**- no cigarettes /lighters/matches/vapes will be allowed on the premises and will be destroyed if brought onto the premises. • No **un-prescribed medication** allowed. Medication containing addictive properties or risk for overdose will be destroyed and will not be given back to the patient at discharge. • **Administration fees** has to be paid in before admission. • Family/support system is encouraged to attend the **orientation group session** on day of admission at 9:30 or 11:30. • Opportunity provided to family/support system to therapeutically join the treatment program and to visit on the Sunday of week 4.

SUPPORT SYSTEM/FAMILY INVOLVEMENT:

- The family/support system is encouraged to attend the orientation group session on day of admission at 9:30am or 11:30am.
- During week 3-5 of the treatment program, the family/support system has the opportunity to therapeutically join the treatment program and attend group sessions, lectures and individual sessions with the patient. Therapeutic involvement in the program has to be arranged and approved by the patient's Toevlug social worker. Accommodation is available on the premises at a cost for overnight stays.
- During the Sunday of week 4 of treatment, the family/support system is allowed to visit the patient from 11am – 2pm. Only two adult visitors are allowed as well as the patient's own children. Visitation have to be arranged and approved by the patient's Toevlug social worker. Only those indicated on the visitors list will be allowed entrance. Sunday lunch options is available at a cost.
- On day of discharge the family/support system is invited to attend the patients certificate ceremony at 8am.
- No family/support system misusing substances are allowed to join the program.

Visitors list:

Visitor 1:

Name	
Surname	
Identity number	
Relationship	

Visitor 2:

Name	
Surname	
Identity number	
Relationship	

Children of the patient: