

APPLICATION FORM: YOUTH INPATIENT PROGRAM

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

Criteria for admission: Only male adolescents. Only ages 13-17 years.

A.	DETAILS OF REFEREE				
Title:		Surname:		Name:	
Occupation:					
Organization:					
Postal Address:			Tel. No.		
			E-Mail		
Are you willing to render aftercare services to the applicant?				YES	NO
If "YES", for what period?					

If "NO", provide details of the person who will provide the **aftercare services**.

Title:		Surname:		Name:	
Occupation:					
Organization:					
Postal address:			Tel. No.		
			E-Mail		

B.	PERSONAL DETAILS OF YOUTH							
B1.	IDENTIFYING DETAILS OF THE YOUTH							
Surname:								
Name(s):								
Date of birth:					Age:			
Identity No.:								
Gender:								
Sexual orientation:	Hetero-sexual		Homo-sexual		Bi-sexual		Other	
Home Language:				Other languages:				
Religion:	Christian		Islam		None		Other	
Denomination:								
Attending school:	Yes				No			
Residential address:								
	Postal code:							

B2	IDENTIFYING DETAILS OF PARENTS/ LEGAL GUARDIANS		
A.	MOTHER/ LEGAL GUARDIAN		
	Surname		
	Names		
	Occupation		
	Identity No		
	Home address		
		Postal	

		code	
	Tel. No.	Home	
		Work	
		Cell	
B.	FATHER/ LEGAL GUARDIAN		
	Surname		
	Names		
	Occupation		
	Identity No		
	Home address		
		Postal code	
	Tel. No.	Home	
		Work	
		Cell	

C.	YOUTH'S PERSONAL CIRCUMSTANCES
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C1. Provide relevant information regarding the **youth's childhood**, e.g. Family home, general development, academic history, family structure and parents' marital status, etc.

C2. Provide information regarding the youth's current **family relationships** (relationships with parents/guardian, siblings, etc.)

C3	Are there any signs of the following within the home to which the youth will return after discharge?		
	YES	NO	If "YES", describe who and the circumstances:
Substance use			
Family violence			
Dealing/selling of alcohol/drugs			
If "YES", report whether there is a strategy to address this:			

D.	SCHOLASTIC BACKGROUND		
1.	Age started school		Age left school
If school was left, why, and is there a strategy for returning to school?			

2.	Progress at school	Good		Average		Poor	
Remark:							
3.	Name of School						
	Address						
		Postal code					
		Tel. No.					
		E-Mail					
4.	Highest grade passed						
5.	Year passed						
6.	Relationship with teachers	Good		Average		Poor	
7.	Relationship with friends at school	Good		Average		Poor	
Remark:							
8.	Problems at school and educational challenges :						
	Abscinding		Disabilities		Low intellectual ability		
	Suspension		Attention deficit		Cannot read or write		
	Lack of motivation		Other:				

9.	Language skills	High		Average		Low	
	Talk						
	Read						
	Write						
10.	Does the youth have any skills, hobbies, sports or interests? Please specify						

E.	SUBSTANCE ABUSE PROBLEM	
E1.	Substance abuse questionnaire <i>(Mark with X)</i>	
When considering the youth's substance use over the past 12 months, which of the following statements apply:		X
1.	Does the youth use the substance in larger amounts or for longer than they intended to?	
2.	Does the youth want to cut down or control substance use but can't?	
3.	Does the youth spend a lot of time obtaining, using, or recovering from the substance?	
4.	Does the youth experience cravings or urges to use the substance?	
5.	Does the youth fail to fulfil responsibilities at home or school due to substance use?	
6.	Does the youth continue using the substance despite problems it causes in relationships?	
7.	Has the youth given up important social, school, or recreational activities due to substance use?	
8.	Does the youth use the substance repeatedly despite physical or psychological harm?	
9.	Does the youth continue using the substance despite developing a physical or psychological problem likely caused or worsened by the substance?	
10.	Does the youth need to use more of the substance to achieve the desired effect? (Tolerance)	
11.	Does the youth experience withdrawal symptoms that are relieved by taking more of the substance?	

E2.	A. Primary substance	B. Secondary substance
Substance		
For how long		
Degree of abuse – how much and how often		
Age when started		

Other substances:

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

E3. PREVIOUS TREATMENT				YES	NO
If "YES", complete the following:					
Name of Centre	Date admitted	Duration of treatment	Completed treatment		
			Yes	No	

If previous treatment was not completed, state reason for early discharge:

F. CRIMINAL BACKGROUND															
<table border="1"> <tr> <th>Nature of transgression</th> <th>Date</th> <th>Sentence</th> </tr> <tr> <td> </td> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> <td> </td> </tr> </table>	Nature of transgression	Date	Sentence												
Nature of transgression	Date	Sentence													

Are there pending court cases?	YES		NO	
If "YES", provide detail:				
Is the applicant involved with gangs?	YES		NO	
Which gang?				
For how long?				
Position in gang?				

G. SEXUAL ORIENTATION & TRAUMA									
1.	Sexual orientation:	Hetero-sexual		Homo-sexual		Bi-sexual		Other	
2.	Any sexual orientation/ preferences which could make the youth vulnerable?								
3.	Any concern regarding the youth's sexual behaviour?								

4.	Has the youth been a victim of any physical, emotional or sexual abuse?
5.	Has the youth been a victim of any crime, e.g. assault, robbery, etc.?
6.	Has the youth been involved with any traumatic events such as car accidents, operations, etc.?

H.	PERSONALITY AND ATTITUDE				
1.	Indicate the youth's attitude towards himself:				
	Positive	YES		NO	
	Believes in himself	YES		NO	
	Positive self-image	YES		NO	
2.	Negative attitude towards authority	YES		NO	
3.	Does the youth have insight in the consequences of his behaviour?	YES		NO	

I.	BEHAVIOURAL PROBLEMS	
Indicate which of the following behaviour problems are displayed by the youth:		
1.	Aggression	
2.	Theft	
3.	Lying	
4.	Destruction of property	
5.	Arson	
6.	Cursing	
Additional information:		

J.	EMOTIONAL HEALTH BACKGROUND			
Has the youth previously received psychological treatment?		YES		NO
Has the youth previously received psychiatric treatment?		YES		NO
If "YES": Describe what for, when, and medication. (Please attach a copy of discharge letters)				
Is there a history of self-harm?		YES		NO
Has there been previous suicide attempts?		YES		NO
If "YES": Describe (When, Method, Why, Hospitalization)				

K.	MOTIVATION:					
Youth's motivation for rehabilitation		Good		Average		Poor

Youth's insight regarding the negative impact of his dependency problem	Good		Average		Poor	
Remarks regarding insight and motivation:						

L. PAYMENT DETAILS (COMPLETE L1 OR L2)						
L1. MEDICAL AID (Please attach copy of medical aid card)						
Name of medical aid			Medical aid no			
Option/ plan			Patient's medical aid code e.g. 01, 02 etc.			
Authorization no			Date	20.... / /		
Full name of main member						
E-Mail						
Postal address						
Town/ City					Postal code	
Tel. no.			ID no			
Note: If the medical aid scheme does not pay out, the parent/guardian of the applicant remains responsible for the account.						

L2. RESPONSIBLE FOR ACCOUNT		<i>(Mark your choice with an 'X' and fill in the details below)</i>					
		Organization		Parent/ Guardian		Other (specify)	
Organization/ Person					<i>(If institution/other person, provide contact person's details below)</i>		
Surname							
Names							
Relation (e.g. Parent/Guardian)							
E-Mail							
Postal address							
Town/ City					Postal code		
Tel. no.							
Payment method	Cash		Cheque		*Electronic		
* Note: In the case of an electronic banking payment, send proof to: accounts@toevlug.org							
Gross monthly income of the youth's mother/legal guardian					R		
Gross monthly income of the youth's father/legal guardian					R		
Note: Attach a copy of the most recent payslip as proof of the aforementioned.							

I,(Initials and Surname of parent/legal guardian) the undersigned, hereby declare that I accept responsibility for the account.	
Signature Date: 20.... / /	

Banking details: Toevlug Sentrum; ABSA Worcester; Branch no: 503107; Account no: 0440850278

M1.	Declaration by the youth's Parent/Legal Guardian
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.... / /	
M2.	Declaration by Referee
I,(Initials and Surname) the undersigned, hereby declare that: • The information in this report is the correct and accurate facts, as provided by the applicant/the applicant's family. I declare that I have not withheld any information from the centre. Signature: Date: 20.... / / Registration number with Professional Council:	

TREATMENT CONTRACT**(NB: This form must be read by the applicant and signed in the presence of the referrer.)**

I, parent/guardian of applicant _____ (Surname and Full names of parent/guardian)
 as well as applicant _____ (surname and full names of applicant), hereby enter into the following agreement with
 Toevlug Centre:

1. I hereby give my consent that I may be admitted as a patient for at least 5 weeks in TOEVLUG and that I will undergo the necessary examinations and treatment, as may be determined by the Manager of TOEVLUG.
2. I accept:
 - A. The household rules of TOEVLUG and promise my full cooperation.
 - B. That the Manager reserves the right to terminate my treatment if I do not fully cooperate in the treatment program.
 - C. That my treatment will be terminated if during my treatment period I bring alcohol/drugs/non-prescribed medication into the centre, use them or hand them over to fellow patients.
 - D. That my treatment will be terminated if I act physically or verbally aggressively towards staff or fellow patients.
 - E. That I accept responsibility for the termination of my treatment program in the event of a breach of the household rules or due to misconduct. I also accept that such termination of treatment will not be withheld because I live far away. In such a case, I as a parent/guardian am personally responsible for the applicant's transportation arrangements and the applicant must leave the center within 1 hour of discharge.
3. I undertake not to bring, have collected, use or assist anyone else in obtaining any alcohol, drugs or non-prescribed medication on the grounds of TOEVLUG. Because I have come for rehabilitation, I will voluntarily cooperate with the following:
 - A. I will, in the interest of all of us, report it to the staff if anyone, to my knowledge, is in possession of, uses or offers alcohol or drugs to me or others. If asked, I will tell the truth.
 - B. I voluntarily submit to tests for the use of prohibited substances according to the procedures of TOEVLUG.
 - C. I will at all times make my luggage, cupboard or storage space available to be searched in the presence of a staff member.
 - D. I voluntarily submit to a search of the centre, my luggage and cupboards by the SAPS dog unit.
 - E. I as a parent/guardian undertake to pay compensation for any damage caused by the applicant to TOEVLUG property.
4. I undertake that no claim will be brought by me or by any person on my behalf against the staff or management of TOEVLUG in respect of the consequences of medical or therapeutic procedures, any accident or misunderstanding or dismissal due to misconduct.
5. I give permission for my social worker/appropriate aftercare group/referrer to be informed of my admission and progress at TOEVLUG.
6. I give permission for my social worker at Toevlug to provide a treatment report of my treatment to my referrer/aftercare worker.
7. I as a parent/guardian accept full responsibility for the applicant's bill/treatment fee calculated according to the parents'/guardians' income per month. TOEVLUG reserves the right to make enquiries regarding the income amounts stated. If this agreement is breached, I will still be held responsible for the applicant's full bill/treatment fee.
8. (Only for patients allocated a subsidized bed): I accept that if this agreement is breached and the applicant does not complete the treatment funded by the Department of Social Development, I will still be held responsible for the applicant's full bill as subsidized by the Department.
9. I understand that my treatment fee/bill must be paid in full prior to admission. I understand that if my treatment program is terminated early, that my treatment fee is non-refundable.
10. I accept that routine detoxification medication is included in the treatment fee/bill, but that I will pay for all other medication myself. If I am already on medication, I will bring enough medication with me for the full period of treatment.
11. I accept that costs will be charged for my family's stay during the period they are enrolled in the treatment program at TOEVLUG.
12. I understand that Toevlug is a smoke-free program and that cigarettes/lighters will be destroyed on the premises. Non-prescribed medication as well as dependency-forming medication will be destroyed upon admission.

I hereby declare that I have read, fully understand and agree to the above terms and conditions.

AGREED AND SIGNED AT _____ (PLACE) ON THE _____ DAY OF
 _____ 20____.

SIGNED: _____
 APPLICANT PARENT/GUARDIAN REFEREE

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: <i>(NB: Attach a copy of the latest results)</i>									
If "YES", what ARV regimen is the patient on and when was the regimen initiated:									
Other current chronic conditions :									
Other current prescribed medication : <i>(NB: Attach a copy of the prescription)</i>									
3. PSYCHIATRIC BACKGROUND: <i>(Psychosis, suicide attempts, depression, DT's, medication, admissions etc.):</i>									
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.

Email: opname@toevlug.org

VISITOR PROTOCOL

1. Only parents/legal guardians may visit the youth. Visitors are limited to only 2 people per youth.
2. Visits must be arranged in advance and approved by the youth's Toevlug social worker. No unplanned visits are permitted.
3. Only parents/legal guardians whose names and identity numbers are filled in on the list below will be permitted. During visiting hours, the names on the list will be compared with the identity documents of the visitors. All visitors must therefore bring identity documents with them when visiting.
4. Visiting hours:
During the fourth week of treatment.
Sundays: 11:00 – 14:00
Public Holidays: No visiting hours
5. Visitors may not provide any cash to the youth.
6. Visitors may not bring any personal belongings, e.g. handbags, cell phones, during visiting hours.
7. No packages may be brought in for the youth.
8. No visitors may:
SMOKE DURING VISITING HOURS!
Go into the youth's bedrooms.
Use Toevlug's equipment or games.
Be under the influence of alcohol or other prohibited substances.
9. The youth may not accompany family to cars after visiting hours.

This list must be completed in full otherwise the youth cannot receive visitors.

VISITOR 1

Name	
Surname	
Identity no	
Relation	

VISITOR 2

Name	
Surname	
Identity no	
Relation	

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	
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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:			

1	Toothpaste and toothbrush	
2	Face cloth and soap	
3	Shampoo	
4	Disposable Razor (Only if applicable. To be stored at the medical department and not in the patient's possession)	
5	Towels (One for swimming and one for shower)	
6	Roll-on (No deodorant)	
7	Hair brush	
8	Underwear and socks	
9	Daily clothing	
10	Sleepwear	
11	Sports clothes and exercise sneakers (For use during sports activities and used in the gymnasium)	
12	One set of formal clothing (For religious ceremony in the morning and discharge ceremony)	
13	Swimming clothes	
14	Washing powder and pegs.	
15	Writing pad and stationary (A5 notebook and pen will be provided on the day of admission)	
16	Bible/Quran	
17	Padlock and key for cupboard	
18	Copy of birth certificate/ ID document	
19	Medical aid card/clinic card	
20	Prescribed medication. Enough for 5 weeks.	
21	Mosquito repellent (On own preference)	
22	Fan (At own risk and own preference)	
23	Clock radio (At own risk and own preference)	
24	School work for the treatment duration	

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. • Earrings, rings, bracelets for men. • Sharp objects/ weapons.	• 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. • Opportunity provided to family/support system to therapeutically join the treatment program as well as to visit on the Sunday during week 4 of treatment.