1. GENERAL INFORMATION:

Personal Information:	
Full Name: …….. **Gender M / F other** L G B T Q	**Date of birth:** ……/……/……
Address: .. …… *(Home)* …… ……	**Id. number:** …… **Passport no:**…….. *(If non-RSA resident)* **Country of residence:** …… *(If non-RSA resident)*
Address: .. …… *(Postal)* …… …… **Next of kin:** *(Please supply the detail of close relatives/acquaintances)* 1. Name: ……... Contact no: ……...	**Tel. no:** Home:(……)…….. Work:(……..)…….. Cell: ..……

2. PAYMENT:

For account enquiries contact Mrs. Ina Jooste:
Tel: 082 468 6919 / Fax: 086 685 8314 / E-mail: info@namaqua-rehab.co.za

NOTE: If you are not a member of a Medical Aid, procedures are not covered, and or funds are depleted, the method of payment is STRICTLY CASH.

To be completed in every instance:	**Medical Aid detail:** *(complete in addition)*
Supply the detail of the person/company responsible for payment: Indicate with X: Self / Sponsor: Full Names: …… Relationship to patient: …….. Telephone no: …….	Name of Medical aid: …… Plan type/name: …… Member no: …… Entry date: …… **Detail of Main member:** Full Names: …… Address: …… …… Tel. No: (……)…… Does this Medical Aid make provision for addiction rehabilitation? Yes / No
Bank detail for internet transfer/deposit: **Branch: FNB Somerset West** **Account No: 6224 5064 283** **Branch No: 200 512** ***Please fax proof of such payment to 086 685 8314***	

3. SCREENING BEFORE ADMISSION:

If you respond "Yes" to any of the following questions, our treatment centre cannot admit you and we will assist you with an alternative referral to another treatment centre:

MARK WITH X

- I am legally referred, awaiting legal action/trial: **YES** **NO**
- I am not yet 18 years old: **YES** **NO**
- I have no financial support and need free treatment: **YES** **NO**
- I feel forced to attend the treatment programme and I am going to be very resistant and troublesome during treatment: **YES** **NO**

4. SUBSTANCE HISTORY:

Have you ever used any of the following other than for treatment of a medical condition under proper supervision of your doctor?

4.1	Amphetamine ("Ecstasy, Ice, MDMA, Speed, Upper, Appetite suppressors, etc.")	**YES**	**NO**
4.2	Methamphetamine ("Tik, Meths, etc.")	**YES**	**NO**
4.3	Cannabis (Dagga) [e.g. "Hashish, Marijuana, Pot, Weed, etc."]	**YES**	**NO**
4.4	Cocaine ("Coke, Crack, Snow, etc.")	**YES**	**NO**
4.5	Hallucinogens (e.g. "Acid, Angel dust, Haze, LSD, etc.")	**YES**	**NO**
4.6	Methaqualone (Mandrax) ["Whites, Buttons, bandits etc."]	**YES**	**NO**
4.7	Opiates ("Codeine, Heroin, Methadone, Morphine, Opium, Smack, cough remedies)	**YES**	**NO**
4.8	Sedatives (e.g. "Diazepam, Downers, Nitrazepam, Tranks, tranquilizers, sleeping tablets, etc.")	**YES**	**NO**
4.9	Solvants (e.g. " glue, aerosols, etc.")	**YES**	**NO**
4.10	Alcohol	**YES**	**NO**
	Did you use any of the above together with prescribed medication?	**YES**	**NO**
	Other	**YES**	**NO**

If you answered yes to any of the above, the following additional information is required:

- What type of drugs/alcohol did you use?

  ……..……..…

  ……..…

  ……..…

- The date (year) on which you started to use the drugs/alcohol?

  ……

  ……

- The last date on which you have used the drugs/alcohol?……....

  ……..…

- How many times did, or do you use drugs/alcohol per month?

  ……

- Have you ever been involved in violent acts, or did you ever transgress any of the laws of the country, or clash with the police, or violated conditions of a protection order against you? *(state all relevant detail)*

  ..……

  ……..…

5. PREVIOUS INTERVENTIONS:

Have you attended any other rehabilitation programmes in the past? **YES** **NO**

If **YES,** indicate:

- Name of rehab? ……
- Dates of admission: ……
- Personal experience with the rehab programme: ……

  ……
- Reason for relapse? ……

6. MEDICAL HISTORY:

6.1 Personal medical history:
Mark with X – if YES, give full detail in each instance:

- Birth process complications: **YES** **NO**

  ……
- Developmental problems: **YES** **NO**

  ……
- Childhood illnesses: **YES** **NO**

  ……
- History of epilepsy: **YES** **NO**

  ……
- Seizures: **YES** **NO**

  ……
- Attention Deficit Disorder with or without Hyperactivity: **YES** **NO**

  ……
- Psychological problems: **YES** **NO**

  ……
- Adjustment problems: **YES** **NO**

  ……
- Social adjustment problems: **YES** **NO**

  ……
- Accidents/injuries: **YES** **NO**

  ……
- Operations: **YES** **NO**

  ……
- Psychiatric consultations: **YES** **NO**

  ……

- Aggressive behavior: **YES** **NO**

……..

- Suicidal thoughts/attempts: **YES** **NO**

……..……

- Other relevant medical history not mentioned above: **YES** **NO**

……..……

6.2 Current medical conditions:
(E.g. diabetes, high blood pressure, heart problems, asthma, epilepsy, psychiatric/psychological problems)

……

6.3 Medication currently used:
(The official/original doctors' prescription needs to accompany the patient in order to be able to continue with such medication during treatment)

Prescribed Medication:	Medical/Psychiatric Conditions:

7. Risk Assessment:

Please answer YES/NO to the following (MARK WITH AN X):

- Do you feel socially isolated? **YES** **NO**
- Do you feel out of control on the substance (a lower sense of self-control) **YES** **NO**
- Do you have any psychiatric/psychological problems (e.g. depression, anxiety, bipolar disorder etc.?) **YES** **NO**
- Do you have a chronic medical illness that worries you a lot? **YES** **NO**
- Any previous suicide attempts? **YES** **NO**
- Did you lose something (relationship, money, job, child, loved one)? **YES** **NO**
- Do you experience feelings of hopelessness? **YES** **NO**
- Has life lost its meaning for you? **YES** **NO**
- Do you hear voices in your head that tell you to harm yourself? **YES** **NO**

8. DOCTOR'S CLINICAL FINDINGS (as at examination):

8.1 Complaints (Reason why help is needed at this stage)

……

……..

8.2 Illnesses (Medical/surgical, current medication)

……

……

8.3 Previous history of psychiatric illnesses: (diagnosis, treatment, and hospitalization)

……

……

8.4 Family illnesses (Psychiatric and other)

……

……

8.5 Substance history:

- Is the patient addicted to a chemical substance, or does s/he use the substance to cope - possibly resulting in addiction in the future? **YES** **NO**
- Does the patient have a substance dependency? **YES** **NO**
- Does the patient use the substance to cope with a co-morbid psychological/psychiatric condition, and is not yet addicted to the substance? **YES** **NO**

  If YES, please motivate: ……
- Is the patient currently, for a lengthy period, on prescribed medication (not substance) due to a psychological/psychiatric condition, which resulted in a need of intense psychological therapy to overcome the problem? **YES** **NO**

  If YES, please motivate: ……

8.6 Detoxification:

NB: All Alcohol, Opiates and Benzodiazepine dependency should first be detoxified
(As stipulated by the protocol of in-patient treatment)

- Is there a need for detoxification? **YES** **NO**
- Who needs to take care of the detoxification process? (In case of patients from afar, our local doctors prefer to do the detoxification at Vredendal Hospital as they are responsible for the patient whilst in treatment at NTC. However, should the patient be in a crisis, detoxification could be done elsewhere and then referred to our Centre.)
  - The referring doctor: ……Location: ……..……..
  - The treating doctor: …… (At Vredendal Hospital)

9. CLINICAL IMPRESSION (as at examination):

Appearance and behaviour:.....

Level of consciousness: .....

Orientation (person, place, and time) .....

Attention level: .....

Mood disturbance.....

Affective impression : .....

Suicidal risk / previous attempts: .....

Thought processes: .....

Perceptions (hallucinations): .....

Memory impairment: .....

Delusions: .....

Level of intelligence: .....

Acceptance of substance addictive problem: .....

Sleeping patterns: .....

Eating patterns: .....

Energy levels: .....

Sex drive: .....

10. PROVISIONAL PSYCHIATRIC DIAGNOSIS:

Provisional until verified by psychiatrist
Please indicate the ICD10 codes as required by the Medical Aids for authorization, where needed

- Axis 1 Psychiatric diagnosis : *DSM IV and ICD 10 codes are essential*
  .....
  .....
- Axis 1 Differential diagnosis on Axis 1; Psychiatric diagnosis : *DSM IV and ICD 10 codes are essential*
  .....
  .....
- Axis 2 Personality factors, development deficiencies:
  .....
  .....
- Axis 3 Medical conditions:
  .....
  .....
- Axis 4 Psycho-social stressors:
  .....
  .....
- Axis 5 Level of personal function:
  .....

11. ANY RECOMMENDATIONS:

General:

……

……

……

Will you recommend that his/her family, spouse, or caregiver needs to be involved in the treatment programme, and why do you recommend that?

……

……..

Do you need to get feedback from the centre on progress and prognosis? ……..…….....

12. AUTHORIZATION:

NOTE: *For Medical Aid authorization, contact Mrs. Ina Jooste of Namaqua Treatment Centre (NTC):*
Tel: 082 468 6919 / Fax: 086 685 8314 / E-mail: info@namaqua-rehab.co.za
The referring doctor/psychiatrist will provide NTC with treatment codes needed for admittance authorization, which is the reason you need to consult with your doctor/psychiatrist.

The Medical aid requires the following particulars:
(Phone Namaqua Treatment Centre to obtain relevant information in all cases)

(Please provide where applicable		
Name of institution:	**Namaqua Treatment Centre**	Practice no: 047/001/0359386
Physician:	……..	Practice no: …….
Psychologist:	……	Practice no: …….
Psychiatrist:	……	Practice no: ……..…
Other:	……	Practice no: ..……..
	……	Practice no: ……..…
	……	Practice no: ..……..
Treatment codes (ICD10)		
Detoxification:	……	
Alcohol rehabilitation: *(In-patient treatment)*	……	
Drug rehabilitation: *(In-patient treatment)*	……	
Co-morbid psychiatric conditions:	……	
Other:	……	
Medical aid :		
Authorization No:		
Tel nr :		

Fax nr : **Postal Address:**	…… …… …… …… …… ……	

Detail of Medical Doctor/Psychiatrist:

Name:	Practice no:
Occupation:	Organization:
Telephone no:	Fax no:
E-mail address	
Street address: Code:	Postal address: Code:
Signature:	Date:

DECLARATION OF PATIENT:

- I declare and guarantee that the above-mentioned information is true, complete, and precise.
- I agree that I hereby give my full co-operation and accept my responsibility in the process of recovery

Signed at:	
Signature:	Date:

WE STRIVE TOWARDS:

A healed person is not the original person minus the symptoms, but a newly orientated person that can manage the problem with the new orientation

The program that is presented at Namaqua Treatment Centre, is based on psychological, medical, and psychological therapeutic approaches, which offers comprehensive assistance of the underlying emotional problems (why the need for substance use exists); done in conjunction with a psychologist, doctors, psychiatric sister, and counselors.

…A Programme that focuses on humanity as a whole…