WeDoRecover.com

- All information received will be treated confidentially.
- By completing this form and emailing it to us you consent to us divulging your information contained in this completed form to clinics we deem appropriate to meet your needs. Your information *will not* be shared with anyone else by WeDoRecover.com
- Be as accurate as possible and provide as much detail as possible when completing the form.

Please email the completed form to hope@wedorecover.com

If you wish to speak to someone for clarification on any question related to this form or treatment, please call 0808-267-3422 UK Freephone or in South Africa on 082-747-3422.

Patient Information

Referrers Name:

Relationship to Patient:

Telephone Number(s):

E-mail Address:

Patient's Name: Age: Gender:

Marital Status: No. of Children:

Doctor's Name and Address:

Tel. No.:

Employed/Unemployed: Occupation:

Present Addictive Pattern (Daily, Binge, Full Time):

Patient's Current Situation (Work & Home Life):

Previous Detoxifications & Treatment (Please describe):

Current Medication the Patient is Taking:

Previous/Outstanding Court Cases:

Please provide additional information to all “yes” answers below.

- Is the patient unable to manage their personal health problems:
- Is the patient in poor physical health:
- Has the patient’s mobility been affected by the use of alcohol or drugs:
- Is the patient in regular contact with a violent or abusive third party:
- Has the patient history of violence/aggression toward people:
- Has the patient ever used a weapon to assault another person:
- Has the patient a known history of convictions for violent/sexually inappropriate behaviour:
- Is patient expressing thoughts of suicide or death:
- Has the patient ever made a previous attempt on their life:
- If yes, was it within the last 4 years and did they use a violent method, i.e. shooting/hanging:
- If yes, does the patient feel anything has changed since the last attempt:
- Has the patient ever overdosed, or deliberately self-harmed, i.e. cutting, burning self etc.:
- Has the patient been diagnosed as suffering from a severe mental illness:
- Has the patient experienced severe childhood trauma:
- Is the patient isolating from friends and family:
- Is the patient accessing treatment under their own volition:
- Has the patient had previous treatment episodes:
- Does the patient believe there is *no solution* to their problems:
- Has the patient ever shared injecting equipment:
- Is there a history of testing and/or treatment for blood-borne disease / viruses: (Hep B, C & HIV)
- Has the patient ever engaged in risky sexual behaviours:

Please elaborate on previous treatment episodes:

Current crisis? What's pre-empted this request for treatment?

How will treatment be funded? Please provide details of Medical Aid / PMI (Private Medical Insurance) etc:

Any specific health problems:

Any special dietary requirements:

Additional Information/Comments:

Name of person completing this form:

Relationship to patient:

Signature (if fax or posting):

Today's Date: