

REFERRAL FOR VOLUNTARY ADMISSION

REFERRAL INFORMATION

Date:	
Referring Practice / Facility:	
Referring Person:	
Contact Number:	
Email Address:	
Practice Number:	

SERVICE USER DETAILS

Full Name:	
ID Number:	
Date of Birth:	
Gender:	
Contact Number:	
Address:	
Next of kin Name & Contact Number:	
Work Name & Contact Number:	

ADDICTION / SUBSTANCE USE INFORMATION

Primary Substance:	
Duration of Use:	
Previous Treatment:	Yes / No
If Yes, Where:	
Medical Aid:	Yes / No
Medical Aid Name:	
Membership Number:	

PROGRAMME REQUESTED

NOTES / BACKGROUND INFORMATION

Programme		
21-Day Inpatient Programme	☐	
6-Month Inpatient Programme	☐	
Intervention Services	☐	
Aftercare Programme	☐	

DECLARATION

Signature of Referring Person	
Date	
Stamp	