

Care Centre: _____ Date: _____

For office use only: Please mark patient profile with an X

	Adult		Mental Health		Frail		Both		Sub Ac / Rehab
	Child		Mental Health		Frail		Both		

Referring health establishment details

Name:		Tel:	
Fax:		PT file number:	
Doctor name:		SW name:	
Doctor tel number:		SW tel number:	

Service user details

Name:		Gender		M		F				
DOB:		Age:		ID Number:						
Ethnic Group		B		W		C		I		A
SA Citizen		Y		N	ID Doc available ^(A16)			Y		N
*If no, has an application been made?		Y		N	Which office:					
Grant available?		Y		N	What type:					
Grant number:										

Family Details

Primary caregiver name:	Relationship to user:
Telephone:	Address:
Cell:	Fax:
Alternative contact:	Relationship to user:
Telephone:	Address:
Cell:	Fax:
Family not present and why:	

**APPLICATION FOR ADMISSION TO A
LIFE NKANYISA FACILITY**

Family Details

Is the family aware that all grants / pensions of the user are cancelled on admission to Life Nkanyisa facility?	<input type="checkbox"/>	Y	<input type="checkbox"/>	N
Does the family understand that user will be discharged back to them / the community on completion of rehab?	<input type="checkbox"/>	Y	<input type="checkbox"/>	N
What other facilities have been approached to place the user? Give reason if rejected:				
Has the user been at a Life Nkanyisa facility before: If yes, provide names and dates:				

Application made on (DD) _____ of (MM) _____ (YY) by

Name: _____

Designation: _____

Signature: _____