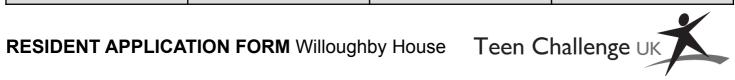
For Office Use Only			
Date Received	Doctor's Letter Received	Interview Date	Date of Entry



1. Contact Details	
▼ APPLICANT	▼ ADDITIONAL CONTACT PERSON
Name:	Name:
Address:	Address:
Postcode:	Postcode:
Contact Telephone No.	
E-mail address:	Contact Telephone No.
	E-mail address:
Date Of Birth:	¬ L
Notice all Incomes as No.	Relationship to applicant:
National Insurance No.	<u>_</u>
Nationality	
2. Family & Living Circumstances of Applicant	
2.1 Marital Status: Single Married	Separated Divorced Widowed
2.2 Number of children: Age(s)	Are you their primary carer? Yes No
Who will be caring for your children if you get accep	ted into Teen Challenge?
2.3 Accommodation: Single Spous	e Parents Friends Other
2.4 Do you own your own house? Yes No	
2.5 Are you a council tenant? Yes No	2.6 Are you a private tenant? Yes No
2.7 Are you currently employed? Yes No	
If yes, name of employer:	
2.8 Are you currently on benefits? Yes N	0
If yes, details:	

3. Accommodation							
3.1 Have you ever lived in a suppo	orted housing enviror	nment? Yes	No				
3.2 Have you ever breached the terms of a tenancy for which there were statutory							
grounds for possession, or br	eached the terms of	a mortgage? Yes	N	o 🗌			
If yes, give details:							
3.3 Have you ever committed acts residents in a place where you		against staff or other	No.				
If yes, give details:							
3.4 Where have you lived over the	past 2 years?						
3.5 Who has provided support for (professional, workers, volunta			ers)				
(	<b>,</b> 9	<u> </u>					
4. Health				-			
4.1 Height:	4.2 Weight:						
4.3 How would you describe your	present health?	Good	Fair	Poor			
4.4 Do you have any physical impa	airment, chronic dise	ase or disability?	Yes	No			
If yes, give details:							
4.5 <b>Do</b> you require assistance with	n daily activities as a	result of any impairm	ent? Yes	No			
If yes, give details:							
4.6 Name of GP or last Doctor see	n						
Name:		Telephone:					
Address:		<u> </u>					
, tau 1990							
4.7 Prescribed medication:							
1.	2.	3.					

5. Substance Misuse				
5.1 <b>Do you use alcoho</b>	I? Yes	No No		
5.2 Do you use drugs?			If yes, do you inject?	Yes No
5.3 What is your prima	ry substance?	?		
5.4 Do you require a m	nedical detox?	Yes	No	
5.5 About your usage:				
Type of Substance	Dosage	Frequency	How long have you	pen using this substance?
Alcohol		rrequency	Tiow long have your	ven using this substance.
Heroin				
Methadone				
Subutex				
Amphetamines				
Cocaine/Crack				
Ecstasy				
Diazepam				
Canabis				
Legal highs				
Other(s)				
5.6 Are any of the above	ve prescribed	to you? Yes	No	
If yes, which ones?				
Name of prescriber:				
Address:				
			:	
Email:				
Phone Number:				
5.7 Have you been a re	esident of a Te	en Challenge centre	before? Yes	No
If yes, w	here?			
5.8 Are you currently s	supported by a	a drug/alcohol agenc	y? Yes	No
lf ves. ai	ve details:			
, , <del>g</del> .				

6. Mental / Emo	otional Health				
6.1 <b>Have you eve</b>	er experienced me	ntal or emotion	al health problems?	Yes	No
lf	yes, give details:				
6.2 Have you ever seen a psychiatrist?				Yes	No
6.3 Are you curr	ently under psychi	iatric care?		Yes	No
lf y	yes to 6.2/6.3, pleas	se give details of	your Psychiatrist, CPN o	or other:	
Name:					
Address:					
Email:					
Phone Number:					
lf	yes, give details:				
6.5 <b>Are you pres</b>	cribed any medica	ition for mental	or emotional health iss	sues?	
If	yes, give details:			Yes	No
	yes, give details.				
Me	dicine	Dosage	Frequency	Whe	n did you start?
1.					
2.					
3.					
4.					
6.6 <b>Have you ev</b> e	er had an eating di	sorder, attempt	ed suicide and/or have	been known to	self harm?
				Yes	No
If	yes, give details:				

7. Past Offences		
7.1 Do you have a criminal record?	Yes	No
If yes, give details:		
7.2 Have you spent any time in prison?	Yes	No No
If yes, when & how long:		
7.3 Do you have any outstanding warrants?	Yes	No
If yes, give details:		
7.4 Do you have any outstanding court appearances?	Yes	No
If yes, give details:		
7.5 Have you ever been prosecuted for any violent offences?	Yes	No
If yes, give details:		
7.6 Have you ever been prosecuted for any sexual offences?	Yes	No
If yes, give details:		
7.7 Have you ever been prosecuted for arson?	Yes	No
If yes, give details:		
7.8 Are you subject to any statutory supervision or probation?	Yes	No
If yes, give details:		
Name:		
Address:		
Phone Number:		

•	wn words why you want	to come to reen Challenge.		
_				
References				
ase provide the detai	ls of two references (e.g.	Doctor, Drugs Worker, Chur	ch Worker, Minis	ster or Social Wo
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## 10. Consent & Declaration

In order to make a decision about your admission to Teen Challenge it may be necessary to contact workers or agencies that have been involved with you. We will only contact people with your permission and any information received will be treated as confidential.

It should be remembered, however, that to process your application you must complete all the information requested on this form. Your application might be held up if we are unable to liaise with other workers. To complete your application it may be necessary to share information given during your assessment with other relevant services.

I, D.O.B
Of (present address)
give Teen Challenge permission to act on my benait regarding my benefits and acquire any information concerning my history from my doctor throughout the duration of my programme.  I also give my consent for the staff from Teen Challenge to obtain written and/or verbal information about me from the following people for the purpose of assisting in my assessment
with Teen Challenge:  GP
I have completed this application form truthfully and to the best of my knowledge.
I understand that any misleading information could jeopardise my entrance into the programme or my remaining on it.
Signed: Date:

If you are completing this form electronically please note you will need to print off the consent & declaration page and the health Information Sheet and send it by post to Teen Challenge.

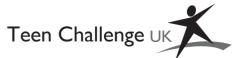
## Please send the completed form to:

Willoughby House Station Road Upper Broughton Nottinghamshire LE14 3BH

Fax: 01664 823 353

or email: admissions@teenchallenge.org.uk

For more information contact Teen Challenge UK on 01664 822221, email info@teenchallenge.org.uk or visit our website: www.teenchallenge.org.uk Teen Challenge UK is a registered Charity.



Please Print this page and take it to your G.P. to be completed, then return this page along with your application form to Teen Challenge UK. You can send us your application by email, fax or post.

	To be completed by your G.P.						
Patient Name:							
NHS Number:						Date Of Birth:	
To your knowled	dge has t	his patient d	etoxed before	?		Yes	No
If yes, could you give details:							
Are you curren	tly prescr	ibing this pa	itient any med	lication?		Yes	No
If yes, what med dosage and freq							
Has this patien	t had any	mental heal	th problems?			Yes	No
If yes, could you give details:							
Is this patient b	eing pres	scribed any a	anti-psychotic	medication?		Yes	No
If yes, could you give details:	l						
Is there any me participate in a						t Yes	No
If yes, what wou reason be:	ld that						
Doctors Signa	iture:					Date:	
P	V Upper Br	villoughby Ho Station Roa oughton Notti LE14 3BH	d inghamshire			octors tamp:	
or e			nchallenge.org.	uk			

For more information contact Teen Challenge UK on 01664 822221, email info@teenchallenge.org.uk or visit our website: www.teenchallenge.org.uk Teen Challenge UK is a registered Charity.