

Date Received: _____	Doctors Letter Sent: _____	Interview Date: _____
----------------------	----------------------------	-----------------------



Resident Application Form

Hope House, 6 Church Road, Gorslas, Llanelli, Carmarthenshire
SA14 7NF Tel: 01269 844114 Fax: 01269 833168

Name: _____ Contact Name: _____

Present Address: _____ Address: _____

Phone Number: _____ Contact Relationship: _____

D.O.B.: _____ Nationality: _____ Phone Number: _____

Birthplace: _____ Mobile Phone: _____

Accommodation: Alone Spouse Parents Friends Other: _____

Do you own a house or flat? No Yes Are you are council tenant? No Yes

Marital Status: Single Married Separated Divorced Widowed

Number and ages of Children _____

Are you currently employed? No Yes If yes, with whom? _____

N.I. No.: _____ Benefits Claimed: _____

Please summarise your employment history: _____

Please summarise your educational history: _____

Substance Misuse History

Type of Drug	Age of 1st use	Age of last use	Frequency of use	Dosage	Route of admin
Alcohol					
Amphetamines					
Barbituates/Downers					
Cocaine/Crack					
Ecstasy					
Heroin					
Cannabis					
Methadone					
Tobacco					
Other:					

What is the primary substance you are now using? _____

How much do you spend daily on drugs? _____

Have you ever breached the terms of a tenancy for which there were statutory grounds for possession, or breached the terms of a mortgage? No Yes

If yes, please give details: _____

Have you ever committed acts of physical violence against staff or other residents in a place where you were living? Yes No

If yes, please give details: _____

GENERAL HEALTH

How would you describe your present health? Excellent/ Good/ Fair/ Poor

Are you taking any prescribed medication? If yes, list medication and dosage

Do you have a physical impairment, chronic disease or any other disability?

Do you require assistance with activities of daily life as a result of this impairment? (e.g. mobility problems/visual impairment or hearing difficulties) _____

Have you ever had an Eating disorder? Yes No

If yes, Anorexia Bulimia

Are you still suffering from an eating disorder? Yes No If yes, please give details:

Have you ever seen a psychiatrist? Yes No

Have you ever experienced mental or emotional health problems? Yes No

If yes, please give details _____

Have you ever spent time in hospital as a result of your mental health problems? Yes No

If yes, please give details: _____

Psychiatrist's Name: _____ Telephone Number: _____

Address: _____

GP's Name: _____ Telephone Number: _____

Address _____

References

Please give the name and address of two referees e.g. a doctor, drugs worker, church worker, pastor or social worker who have known you for more than 6 months

- 1) Name: _____
Address: _____

Profession: _____ Tel No.: _____
- 2) Name: _____
Address: _____

Profession: _____ Tel No.: _____

Declaration

I give Teen Challenge permission to act on my behalf regarding my benefits and acquire any information concerning my medical history from my doctor throughout the duration of the programme.

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.**

Print Name: _____ Date: _____

Signature: _____

Please send your completed form to:
Hope House
6 Church Road
Gorslas
Llanelli
Carmarthenshire
SA14 7NF
Tel: 01269 844114 Fax: 01269 833168

Registered Charity No. 298900

Dear

I hereby give consent for my medical records or reports to be sent to Teen Challenge in view of my intention to join their 12 month Rehabilitation Programme.

Name of Doctor: _____

Address of Doctor: _____

Name of Patient: _____

Signed: _____ Date: _____