



Treatment Centre for Substance Dependence

PRE-ADMISSION FORM: PATIENT & NEXT OF KIN

Alcohol and Drug dependency can be treated successfully. At Ramot we offer a treatment programme which ensures specialised individual attention for optimal recovery.

Please send form back to:
The Admissions Coordinator
Ramot
54 Toner Street
7500

Telephone: 021 939-2033
Fax: 086 586 0592
E-mail: opnames@ramot.co.za

IMPORTANT PROGRAMME INFORMATION FOR THE REFERRER AND PATIENT

1. All the referrals to Ramot have to be made by a registered professional person, e.g. a social worker, physician, psychiatrist, minister of religion, health professional, Human Resources/EAP etc. (hereafter the "referrer"). The referrer also renders after-care services to the patient or refers such services to a trained professional person. The referrer may not be a family member or friend of the patient.
2. Ramot evaluates patients prior to admission to ensure maximum benefit will be derived from the programme. In cases of e.g. senility, retardation, psychosis, psychopathy or serious sicknesses, the patient is referred to a suitable institution for specialised treatment.
3. The first 3 - 7 days are spent in the detoxification unit after which the patient does a 4 week psychotherapy programme.
4. Afrikaans speaking patients must understand English as the audio visual programme is presented in English.
5. All private patients need to pay the full tariff prior to or on the day of admission.
6. Patients must please arrive at 08:30 for admission with the required items (e.g. Pocket money, key deposit, cigarettes, and medication).
7. The programme may not be interrupted by court cases or other personal matters. It is in the patient's interest to focus fully on the programme. Please arrange that court cases or other matters be postponed until discharge.
8. Please ensure that everything has been arranged at home/work to enable the patient to focus fully on the treatment programme.
9. Ramot provides a healthy and balanced diet but does not cater for individual food preferences.
10. Aftercare/continued treatment is essential for maintaining sobriety. Please treat aftercare as important as it does contribute significantly to the success of the treatment programme.



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Personal information

Full Names:

Surname:

Identification Number:

Date of birth:

Age:

Gender: Male Female

Home Language:

Home Address:

Postal Code:

Cellphone:

Landline (work):

Landline (home):

Email:

Marital Status:

Occupation:

Church denomination:

Highest school qualification:

Tertiary qualifications:



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Next of Kin

Support base: Next of kin /Friend (preferably with whom the patient is staying)to be contacted in case of emergency and early (self) discharge):

Name:	<input type="text"/>
Relationship:	<input type="text"/>
Date of birth:	<input type="text"/>
Cellphone:	<input type="text"/>
Landline (home):	<input type="text"/>
Landline (work):	<input type="text"/>
Alternative emergency telephone number:	<input type="text"/>
Email:	<input type="text"/>

Please answer the following questions

	Yes	No
Do you need more information on addiction?	<input type="checkbox"/>	<input type="checkbox"/>
Are you in favor of treatment for the patient at Ramot?	<input type="checkbox"/>	<input type="checkbox"/>
Are you prepared to continue your relationship after treatment?	<input type="checkbox"/>	<input type="checkbox"/>
Are you prepared to support the patient in a sober life?	<input type="checkbox"/>	<input type="checkbox"/>
Are you prepared to continue your relationship after treatment?	<input type="checkbox"/>	<input type="checkbox"/>
Please indicate if you will be able to attend meetings at Ramot on Thursday evenings. We recommend it!		
During the treatment period?	<input type="checkbox"/>	<input type="checkbox"/>
After completion of the treatment period	<input type="checkbox"/>	<input type="checkbox"/>



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MEDICAL AID INFORMATION

Please phone your medical aid to obtain an authorization number before admission. They require the following particulars:

Ramot practice no:	0051233
Physician - Dr Practice no	0095672
Treatment codes:	Detoxification F10.2 Alcohol rehabilitation Z50.2 Drug rehabilitation Z50.3

Name of Medical Aid:

Plan/Scheme:

Full name and surname of main member:

Medical Aid no:

ID number:

Medical Aid date joined:

Authorization no:

Telephone number (Medical Aid):

Fax number (Medical Aid):

Postal Address (Medical Aid):

Postal Code (Medical Aid):



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PERSON / ORGANISATION RESPONSIBLE FOR ACCOUNT

Monthly gross salary of patient:

Monthly gross salary of spouse:

Monthly gross salary of Father, Mother, Guardian and/or person responsible for account

Organisation/Company/Employer:

Full name and surname:

ID number:

Address:

Postal Code:

Cellphone:

Landline (work):

Landline (home):

Acceptance of terms: (Complete relevant clause) 1. I, _____ accept that, if the treatment program of the patient, _____, is terminated prematurely, for whatever reason, all monies will be forfeited. 2. In case of a medical fund I, _____ as main member of the fund, accept full responsibility for the outstanding amount if the treatment program of the patient, _____ is terminated prematurely, for whatever reason.

SIGNATURE _____ DATE _____

WITNESS _____ DATE _____

METHOD OF PAYMENT TO RAMOT

Medical Aid:		Cash:		Cheque:		Bank Deposit:	
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Bank details:

ABSA PAROW - Branch code: 632005 - NAME: RAMOT - ACCOUNT: 0390680015

Please fax deposit slip to: 0865860592 or 0219303123

Please attach a copy of your latest salary slip.



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ADDICTION PROBLEM

Please give the patient's own answers to the next 29 questions. False information may lead to discharge.

What substances did you use? Specify

How much did you use per day?

Do you often have a craving for alcohol/drugs?

	YES	NO
Do you use alcohol/drugs when you are worried/tense/or angry?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a craving to use more after the first drink/drug?	<input type="checkbox"/>	<input type="checkbox"/>
Are you currently drinking/using too much?	<input type="checkbox"/>	<input type="checkbox"/>
Do you often drink/use for a few days continuously?	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel shaky or sick in the morning after drinking/using the previous night?	<input type="checkbox"/>	<input type="checkbox"/>
Do you sometimes use alcohol/drugs in the morning ("regmaker")?	<input type="checkbox"/>	<input type="checkbox"/>
Do you sometimes have loss of memory?	<input type="checkbox"/>	<input type="checkbox"/>
Have you considered drinking/using less?	<input type="checkbox"/>	<input type="checkbox"/>
Does your drinking/use affect you family life negatively?	<input type="checkbox"/>	<input type="checkbox"/>
Does your drinking/use create problems at work?	<input type="checkbox"/>	<input type="checkbox"/>
Does your drinking/use create financial problems?	<input type="checkbox"/>	<input type="checkbox"/>
Has your drinking/use caused deterioration in your health?	<input type="checkbox"/>	<input type="checkbox"/>
Have people pressurised you to go for treatment?	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel guilty about your drinking/drug use?	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel your substance use has become a serious problem?	<input type="checkbox"/>	<input type="checkbox"/>
Who is responsible for your addiction?	<input type="checkbox"/>	<input type="checkbox"/>
For how long have you had an addiction problem?	<input type="checkbox"/>	<input type="checkbox"/>
Are you willing to, on a voluntary basis, do the full treatment programme at Ramot?	<input type="checkbox"/>	<input type="checkbox"/>



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PREVIOUS TREATMENT FOR ADDICTION PROBLEM

CENTRE	ADMISSION DATE	PERIOD	PROGRAMME COMPLETED YES/NO	PERIOD SOBER AFTER TREATMENT

JUDICIAL HISTORY

Did alcohol/drugs ever bring you into conflict with the law?

Are there any pending court-cases against you?

Date of court-case?

If charged with a criminal offence, please state what:

Prison sentence?



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PATIENT TO COMPLETE

I the undersigned, _____ agree that I have read this contract and that I willingly agree to abide by the contents thereof:

1. CONSENT

- 1.1 I agree to be admitted as a patient at Ramot Centre.
- 1.2 I agree to undergo the necessary examinations, treatment and searches (including body search) as prescribed.
- 1.3 I have read Addendum 1 in which my medical treatment has been described, I know the contents of Addendum 1 and agree to the possible risks of medical treatment.
- 1.4 I understand that Addendum 1 is, for practical reasons, not all-inclusive. I furthermore give my consent to any other disadvantages or risks that are an intrinsic part of the treatment process, and that may occur through negligence or not, and regardless of the person(s) responsible; whether it is the employees, officers or personnel of Ramot.
- 1.5 In case of an early and self discharge I give Ramot permission to contact my next of kin as set out under "Identification Particulars of Patient" (p 4).
- 1.6 I accept that, if for any reason I will be discharged earlier from my program, all treatment fees will be forfeited for the remainder of the period.

2. DECLARATION

I hereby accept the following conditions:

- 2.1 I accept that my treatment period can be terminated if I withhold information regarding my addiction or if my behavior disrupts my own treatment programme or the therapeutic atmosphere at Ramot.
- 2.2 I accept and understand that should my treatment period be terminated by Ramot for the reasons set out in 2.1 or should I discharge myself prior to the end of the agreed treatment period, my medical aid will only pay for the days on which I was admitted and treated at Ramot and that the balance of the treatment period days will be for my own account.

3. UNDERTAKING

- 3.1 I undertake not to bring any action against Ramot or any of its employees, officers or staff members should I suffer any harm or disadvantage due to my treatment and/or stay, whether through negligence or not.
- 3.2 I undertake to complete the full treatment programme and not to discharge myself prematurely for whatever reason.
- 3.3 I undertake to give my full co-operation to my treatment at Ramot.
- 3.4 I undertake to settle any amount owed by me to Ramot in respect of the provision set out in 2.2 within 30 (thirty) days after my discharge from Ramot.

SIGNATURE (Patient)
(Parent signature (in case of minors))

WITNESS



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THE MEDICAL TREATMENT AT RAMOT CONSISTS MAINLY OF THE FOLLOWING:

1. Sedation in order to ease the withdrawal stage for the patient.
2. Oral vitamin supplements.
3. In the case of previous alcoholic fits or delirium tremens, preventative medication will be administered.
4. Blood tests and X-ray examination to diagnose contagious diseases.
5. Patient may be referred to a hospital should he/she suffers from any condition which requires further medical tests, specialised treatment or emergency medical treatment.

MEDICATION

- Chronic medicine should be adequate for the duration of the treatment programme.
- When necessary an original replication of the prescription for chronic medicine should be provided.
- Medication prescribed/provided by Ramot, different from the detoxification medicine during the treatment programme, will:
 - If the patient belongs to a medical aid, be paid from hospital- or day to day benefits
 - Or paid cash prior to discharge.

I, _____ confirm hereby that expenses incurred by Ramot will be recovered by the following income source:

Circle the appropriate number:

1. Claim from Medical Aid
2. Cash payment prior to discharge

Name:	
Cellphone number:	
Telephone number:	
Date	

SIGNATURE

WITNESS