



ADMISSION FORM

Date of Admission: _____

Name:	Surname:
Address:	ID Number:
Work Tel number:	Cellphone number:
Home number:	Date of birth:
Email address:	Age:
Marital Status:	Dependents:
Pre-existing conditions/ Allergies:	Name of Medical Doctor & Contact Details:
Drugs of Choice:	
Names of previous treatment facilities:	Contact numbers of previous

	treatment facilities:
Next of Kin:	Next of Kin Address:
Cellphone number Next of Kin:	Email address Next of Kin:
Relationship:	Name of employer: Contact for Employer
Name of Medical Doctor:	Medical Aid (include plan/option):
Medical aid number:	Main Member Address:
Authorization Number:	Employer:
Referred by:	Work Number: Cell Number: ID Number:

VALUABLE ITEMS INVENTORY

Please note that all items of value must be preferably sent home with your family for safe keeping

Medication:

Item:

Signed: _____

Previous Hospitalizations:

Name of facility:	Reason for admission:
Name of facility:	Reason for admission:
Name of facility:	Reason for admission:

[illegible]

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[illegible]

Notes:

INDEMNITY FORM

By entering any the Lions Gate Recovery Center Pty Ltd. (Alcohol and Drug Halfway House)

I Name (_____), Surname (_____)

Agreement

I shall indemnify and hold Lions Gate Recovery Center Pty Ltd, it's Directors, Managers, all other members, personnel and associates, volunteers or sponsors harmless against any claim which may be made against Lions Gate Recovery Center Pty Ltd, its Directors, Managers, all other members, personnel and associates, volunteers or sponsors, by any person, arising from or relating to, any harm, injury, loss, damage or destruction (either physical, psychological or to any personal possessions), contemplated above. No Refund Policy. You agree upon the acceptance of this Agreement that we have a no refund policy on all services and products we offer. If the client vacates the facility or is asked to leave the facility for any reason whatsoever the refund policy still applies and is binding to this agreement. By signing this agreement you agree to all the stipulations mentioned above.

Signed on this _____ day of _____ 20____
at _____

Signature of Patient: _____

Witnessed by: _____

Witness Signature: _____