the haven Kilmacolm
Housing Support Service

The Haven Kilmacolm Horsecraigs Kilmacolm Inverclyde PA13 4TH
Tel: 01505 872099 **Email:** info@thehavenkilmacolm.com
Web: www.thehavenkilmacolm.com

Name:

Date of birth:
Age:

National Insurance number:

Phone numbers:

Email address:

Address:

Contact details

Next of kin

Name: .....

Relationship to you:……..

Address: .....
……..
……..

Phone numbers: ……..……

Email address:……...

Person or agency who referred you

Name: .....

Agency: .....

Phone numbers: ……..

Solicitors name: ……..

Phone numbers: ……...

Accommodation (please circle your answer)

Who do you live with? alone spouse parents friend NFA other……

Do you own a house or flat? no yes are you a council tenant? no yes

are you a private tenant? no yes

Marital status & family (please circle your answer)

single married living with partner divorced separated widowed other……

Ages of children: no yes ……

Social benefits & employment (please circle your answer)

Are you working? no yes with whom?……

Benefits: UC ESA PIP/DLA others …… ……..

Date of latest payment: …….. …….. …….. …….. ……..

Amount £ (approx.): …….. …….. …….. …….. ……..

Have you completed an ESA50 (medical questionnaire?) no yes when?……..

Has your benefit stopped recently? no yes

Are you in the 'appeal process'? no yes explain……

Jobs I've had in the past: …… …… ……

…… …… ……

Medical (please circle your answer)

Height: ……. **Weight:** …….

Allergies? no yes what are they?……..

Health problems: mobility hearing vision others …… …… ……..

Need assistance with daily activities due to any impairment? no yes details ……

……..

Treatment by a consultant? no yes when & what for?……..

……..

Eating phobias or disorders? no yes details……

Treatment by a psychiatrist? no yes when & what for?……..

name……phone number…….. ……

Self-harmed? no yes when & details?……..

Overdosed? no yes when & details?……..

Attempted suicide? no yes when & details?……

Have you ever experienced mental or emotional health problems or been hospitalised?

no yes details……

General health at the moment: please describe……

Have you been referred to or get support from a drug/alcohol agency in the last 12 months?

no yes name…… phone number……

details……

Prescribed medications: ……. ……. ……. …….

Substance misuse (please circle your answer)

Smoking? no yes how many per day? ……..

Drinking? no yes type of alcohol …… amount per day? …… .

Drugs? no yes main drug …….. amount per day? …… .

Do you inject? no yes

Substance misuse continued (please complete the table below)

Substance	Amount	How often?	Been using for how long?
Alcohol			
Heroin			
Methadone			
Subutex			
Suboxone			
Diazepam			
Amphetamines			
Cocaine/crack			
Ecstasy			
Cannabis			
Legal highs			
Other			
Other			
Other			

Other residential centres (please list them below)

Centre name	Started	Left	Reason for leaving

Have you ever been violent or verbally abusive to staff or residents in other centres? no yes

Have you ever been asked to leave a residential centre? no yes

Who has supported you recently? (please circle) professionals voluntary groups religious groups

details……

Personal statement

Please write in your own words why you want to come to The Haven Kilmacolm

Offending history & legal matters (please circle)

Criminal record? no yes **Been to prison?** no yes **Outstanding warrants?** no yes

Outstanding court case? no yes **Prosecuted for violent offence?** no yes

Prosecuted for arson? no yes **Prosecuted for sexual offence?** no yes

Are you currently under statutory supervision or probation? no yes

Are you currently involved in a community service order? no yes

References

Please give below the details of a referee (not your doctor) who has known you for at least 6 months

e.g. a minister of religion, church, agency or social worker.

Name: ..... Address: .....

Profession: ..... Phone number: .....

Declaration

I declare that the information given in this application is correct and complete to the best of my knowledge. I understand that THK reserves the right to terminate the Licence Agreement or to take action for possession of any accommodation if it has been gained by giving false information. I give THK full permission to follow up enquiries with my Probation Officer, Social Worker, Psychiatrist, GP or any other person named on this Application Form.

Applicant's Signature

Signature:		Date:	
Print name:			

Data protection

The information provided by you on this form will be stored by THK for the purpose of assisting us in providing services to you. Other information which you may provide in the future may also be stored by THK.

Confidetiality

THK will protect the privacy of individuals, will handle personal information sensitively, and will act at all times in such a way as to protect and promote the best interests of individuals and the organisation. All information will be dealt with in accordance with THK's Confidentiality Policy.

Equal opportunities

The Haven Kilmacolm seeks to provide services on a fair and equitable basis taking into account only the needs of the person who applies for accommodation. No person will be treated less favourably on the grounds of race, colour, ethnic origin, disability or educational status. We promote dignity, privacy, choice, safety, equality & diversity.

This page is blank.

If you need more space you can use this page.

Applicant's name:……

Doctor/GP

This page must be completed by your doctor.

It must be signed by your doctor and stamped with the doctor's address.

I give permission for this form to be completed.

Applicant's signature: .....

To the doctor:- could you please complete this questionnaire regarding your patient named above?

CHI number:……

Has he detoxed before? (please circle) yes no do not know

(if 'yes', please give details)……

Are you currently prescribing any medication? (please circle) yes no

(if 'yes', please give details)

Medication	Dosage	Symptom/illness	Comments

Has this patient a history of mental health issues? (please circle) yes no

(if 'yes', please give details)……

……

psychiatrist, mental health or drug worker **Name:**…… **Phone:**……

Name:…… **Phone:**……

Has this patient any other current health issues? (please circle) yes no

(if 'yes', please give details)……

……

PLEASE TURN OVER

Doctor/GP

Has this patient any blood born diseases? (please circle) yes no don't know

(if 'yes', please give details)……

……..

Are there any medical reasons known to you why this patient should not participate in a residential drug/alcohol detoxification and rehabilitation program? (please circle) yes no

(if 'yes', please give details)……

……

Can you sign and stamp this form please?

Doctor's name:…… Doctor's signature:…….

Date:……

Doctor's address stamp here

Thank you for completing this form.

The Haven

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Psychiatrist/drug worker/CPN/mental health worker

This page must be completed by your Mental Health or Drug worker.

It must be signed by your Mental Health or Drug worker and stamped with the Mental Health or Drug worker's address.

Applicant's name:…….

I give permission for this form to be completed.

Applicant's signature: .....

To Drug worker/Mental Health worker:- could you please complete this questionnaire regarding your patient named above?

Has he detoxed before? (please circle) yes no do not know

(if 'yes', please give details) ……

……

Are you currently prescribing any medication? (please circle) yes no

(if 'yes', please give details)

Medication	Dosage	Symptom/illness	Comments

Has this patient a history of mental health issues? (please circle) yes no

(if 'yes', please give details)……

……

Has this patient any other current health issues that you are involved in diagnosing or treating? (please circle) yes no

(if 'yes', please give details)……

……

PLEASE TURN OVER

Psychiatrist/drug worker/CPN/mental health worker

Are there any medical reasons known to you why this patient should not participate in a residential drug/alcohol detoxification and rehabilitation program? (please circle) yes no

(if 'yes', please give details)……..

……..

Can you sign and stamp this form please?

Mental Health worker's name:…… Mental Health worker's signature:.....

Date:.....

Mental health or drug worker's address stamp here

Thank you for completing this form.

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