

COMCARE APPLICATION FOR RESIDENCY

Date of Application:

NAME: _____

Address: _____

Contact Telephone No: _____

Date of Birth: _____/_____/19____

I.D. No.: _____ Age _____

Religion: _____

Psychiatric Diagnosis: _____

How many admissions have you had to a psychiatric hospital? _____

When was your last psychiatric admission? _____

Where do / did you receive

In-patient treatment: _____

Out-patient treatment: _____

Contact Person / sister at clinic acquainted with you: _____

Name: _____ Tel. No.: _____

File No.: _____ Medical Aid No.: _____

Current psychiatric medication: _____

Do you have a history of substance abuse? _____

If so, what substances? _____

Do you suffer from the following conditions:

Epilepsy ____ Diabetes ____ Asthma ____ Heart Condition ____ Rheumatic Fever ____

High/Low Blood Pressure ____ Allergies: please specify _____

Any other physical condition (specify) _____

If you take medication for any of the above, please specify _____

Who do you currently reside with: _____

Are you married? _____

Do you have any children? _____

Details of next of kin:

Name: _____ Relation _____

Address: _____ Tel No: (H) _____

_____ Tel No: (W) _____

Name: _____ Relation _____

Address: _____ Tel No: (H) _____

_____ Tel No: (W) _____

How many of the following are you able to do for yourself? (please tick)

Administer own medication _____ Administer own money _____

Take care of personal hygiene _____ Cook food _____ Clean room _____

Wash & Iron clothes _____ Tidy the home _____

What means of transport do you use? _____

Daily Activity

Are you currently employed? _____

If so where and what is your position? _____

Have you ever attended a rehabilitation program? _____

If so what program? _____

What do you currently do during the day? _____

INCOME & EXPENDITURE:

INCOME

EXPENDITURE

Source	Amount	Details of Expenditure	Amount

Are you in receipt of a disability pension? _____

If so where is your paypoint? _____

And who administers your Disability pension? _____

Why do you require accommodation at COMCARE? : _____

Please attach any relevant reports: (Mental Health Professional, Psychologist, Social Worker, Occupational Therapists)

**Please return by –
Post Post to: Comcare Trust, P.O. Box 236, Rondebosch, 7700
Fax: 021 448 0761
Deliver to: Comcare Trust, House 20, Valkenberg Hospital,
Observatory, 7935**

**For further information, please contact our office Tel: 021 448 0760 or via
Email: comcaretrust@mweb.co.za**