

Date Received	Doctor's Letter Received	Interview Date	Date of Entry
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RESIDENT APPLICATION FORM Willoughby House

Teen Challenge UK



1. Contact Details

▼ APPLICANT	▼ ADDITIONAL CONTACT PERSON
Name: <input type="text"/>	Name: <input type="text"/>
Address: <input type="text"/>	Address: <input type="text"/>
Postcode: <input type="text"/>	Postcode: <input type="text"/>
Contact Telephone No. <input type="text"/>	Contact Telephone No. <input type="text"/>
E-mail address: <input type="text"/>	E-mail address: <input type="text"/>
Date Of Birth: <input type="text"/>	Relationship to applicant: <input type="text"/>
National Insurance No. <input type="text"/>	
Nationality <input type="text"/>	

2. Family & Living Circumstances of Applicant

2.1 Marital Status: Single Married Separated Divorced Widowed

2.2 Number of children: Age(s) Are you their primary carer? Yes No

Who will be caring for your children if you get accepted into Teen Challenge?

2.3 Accommodation: Single Spouse Parents Friends Other

2.4 Do you own your own house? Yes No

2.5 Are you a council tenant? Yes No 2.6 Are you a private tenant? Yes No

2.7 Are you currently employed? Yes No

If yes, name of employer:

2.8 Are you currently on benefits? Yes No

If yes, details:

3. Accommodation

3.1 Have you ever lived in a supported housing environment? Yes No

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

If yes, give details:

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

If yes, give details:

3.4 Where have you lived over the past 2 years?

3.5 Who has provided support for you over the last two years? (professional, workers, voluntary groups, religious groups, family members)

4. Health

4.1 Height:

4.2 Weight:

4.3 How would you describe your present health? Good Fair Poor

4.4 Do you have any physical impairment, chronic disease or disability? Yes No

If yes, give details:

4.5 Do you require assistance with daily activities as a result of any impairment? Yes No

If yes, give details:

4.6 Name of GP or last Doctor seen

Name:

Telephone:

Address:

4.7 Prescribed medication:

1.	2.	3.
4.	5.	6.

5. Substance Misuse

- 5.1 Do you use alcohol? Yes No
- 5.2 Do you use drugs? Yes No If yes, do you inject? Yes No
- 5.3 What is your primary substance?
- 5.4 Do you require a medical detox? Yes No
- 5.5 About your usage:

Type of Substance	Dosage	Frequency	How long have you ben using this substance?
Alcohol			
Heroin			
Methadone			
Subutex			
Amphetamines			
Cocaine/Crack			
Ecstasy			
Diazepam			
Canabis			
Legal highs			
Other(s)			

- 5.6 Are any of the above prescribed to you? Yes No

If yes, which ones?

Name of prescriber:

Address:

Email:

Phone Number:

- 5.7 Have you been a resident of a Teen Challenge centre before? Yes No

If yes, where?

- 5.8 Are you currently supported by a drug/alcohol agency? Yes No

If yes, give details:

6. Mental / Emotional Health

6.1 Have you ever experienced mental or emotional health problems?

Yes

No

If yes, give details:

6.2 Have you ever seen a psychiatrist?

Yes

No

6.3 Are you currently under psychiatric care?

Yes

No

If yes to 6.2/6.3, please give details of your Psychiatrist, CPN or other:

Name:

Address:

Email:

Phone Number:

6.4 Have you ever been in hospital as a result of mental or emotional health problems?

Yes

No

If yes, give details:

6.5 Are you prescribed any medication for mental or emotional health issues?

Yes

No

If yes, give details:

Medicine	Dosage	Frequency	When did you start?
1.			
2.			
3.			
4.			

6.6 Have you ever had an eating disorder, attempted suicide and/or have been known to self harm?

Yes

No

If yes, give details:

7. Past Offences

7.1 Do you have a criminal record?

Yes

No

If yes, give details:

7.2 Have you spent any time in prison?

Yes

No

If yes, when & how long:

7.3 Do you have any outstanding warrants?

Yes

No

If yes, give details:

7.4 Do you have any outstanding court appearances?

Yes

No

If yes, give details:

7.5 Have you ever been prosecuted for any violent offences?

Yes

No

If yes, give details:

7.6 Have you ever been prosecuted for any sexual offences?

Yes

No

If yes, give details:

7.7 Have you ever been prosecuted for arson?

Yes

No

If yes, give details:

7.8 Are you subject to any statutory supervision or probation?

Yes

No

If yes, give details:

Name:

Address:

Phone Number:

8. Personal Statement

8.1 Please write in your own words why you want to come to Teen Challenge.

9. References

Please provide the details of two references (e.g. Doctor, Drugs Worker, Church Worker, Minister or Social Worker) who has known you for the past six months.

9.1 Reference 1

Name:

Profession:

Address:

Phone Number:

Email:

9.2 Reference 2

Name:

Profession:

Address:

Phone Number:

Email:

10. Consent & Declaration

In order to make a decision about your admission to Teen Challenge it may be necessary to contact workers or agencies that have been involved with you. We will only contact people with your permission and any information received will be treated as confidential.

It should be remembered, however, that to process your application you must complete all the information requested on this form. Your application might be held up if we are unable to liaise with other workers. To complete your application it may be necessary to share information given during your assessment with other relevant services.

I, <input type="text"/>	, D.O.B	<input type="text"/>		
Of (present address)				
<input type="text"/>				
<i>give Teen Challenge permission to act on my behalf regarding my benefits and acquire any information concerning my history from my doctor throughout the duration of my programme.</i>				
<i>I also give my consent for the staff from Teen Challenge to obtain written and/or verbal information about me from the following people for the purpose of assisting in my assessment with Teen Challenge:</i>				
GP <input type="checkbox"/>	Probation Officer <input type="checkbox"/>	Psychiatrist/CPN <input type="checkbox"/>	Social Worker <input type="checkbox"/>	Drugs Worker <input type="checkbox"/>
<i>I have completed this application form truthfully and to the best of my knowledge.</i>				
<u><i>I understand that any misleading information could jeopardise my entrance into the programme or my remaining on it.</i></u>				
Signed:	<input type="text"/>	Date:	<input type="text"/>	

If you are completing this form electronically please note you will need to print off the consent & declaration page and the health Information Sheet and send it by post to Teen Challenge.

Please send the completed form to:

Willoughby House
Station Road
Upper Broughton Nottinghamshire
LE14 3BH

Fax: 01664 823 353

or email: admissions@teenchallenge.org.uk

For more information contact Teen Challenge UK on 01664 822221, email info@teenchallenge.org.uk or visit our website: www.teenchallenge.org.uk Teen Challenge UK is a registered Charity.

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Please Print this page and take it to your G.P. to be completed, then return this page along with your application form to Teen Challenge UK. You can send us your application by email, fax or post.

To be completed by your G.P.

Patient Name:

NHS Number:

Date Of Birth:

To your knowledge has this patient detoxed before?

Yes No

If yes, could you give details:

Are you currently prescribing this patient any medication?

Yes No

If yes, what medication, dosage and frequency:

Has this patient had any mental health problems?

Yes No

If yes, could you give details:

Is this patient being prescribed any anti-psychotic medication?

Yes No

If yes, could you give details:

Is there any medical reasons known to you why this patient should not participate in a drug detoxification and rehabilitation programme?

Yes No

If yes, what would that reason be:

Doctors Signature:

Date:

Please send the completed form to:

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Fax: 01664 823 353
or email: admissions@teenchallenge.org.uk

Doctors Stamp:

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