BIO-PSYCHOSOCIAL REPORT TEMPLATE FOR CENTRALIZED ADMISSIONS

Western Cape Government
Social Development

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Please indicate which Treatment Centre you wish to apply to :

The Salvation Army Hesketh King Treatment Centre 16-20 Youth Program ☐
(Youth Program 7 Weeks)

The Salvation Army Hesketh King Treatment Centre 21+ Adult Program ☐
(Adult Program 12 Weeks)

Lindelani Treatment Centre For Substance (9 Week Program) ☐

De Novo Treatment Centre For Adults and Youth (9 Week Program) ☐

Kensington Treatment Centre For Adult Females (9 Week Program) ☐

PROFESSIONAL REPORT BY

Full name: …….. (compulsory)

Signature: ……... (compulsory)

Qualification/s: ……

Address: ……

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Tel: …….. (compulsory)

Fax no: …….. (compulsory)

Email: …… (compulsory)

Date: ……

Supervisor: …… Date: ……

Supervisor's signature ……

IDENTIFYING INFORMATION		
Surname		
Name		
Date of birth		
Identification Number		
Sex		
Race		
Marital Status		
Dependencies		
First (home) language		
Second Language		
Current Address		
Discharge Address		
Contact numbers		
Occupation/employment details(if applicable)		
Referral - Adults	Voluntary (Sec 32)	
	Involuntary/Committal (Sec 33&35)	
	Children's Act, 38,2005	
	Committal after conviction [296] (36& 37)	
Referral – Adolescents	Child Justice Act, 74, 2008	
	Children's Act, 38,2005	
	Substance Abuse Act, 70 of 2008	
Referral Source: designation, name & surname	Social worker	
	Other occupations	
Referral Source: Organization, address & contact detail		
Identification information of visitors whilst in treatment	Name: ID Number: Relationship/Link with the service user: Contact numbers:	

SOURCES OF INFORMATION	

REASON FOR REFERRAL/CIRCUMSTANCES FOR REFERRAL

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SUBSTANCE USE HISTORY (pattern of use)

	Drug of choice			
	1st	2nd	3rd	
Inhalants				
Drugs				
Alcohol				
Cigarettes				
Other / Behaviour Problems				

PRESENT ILLNESS/SUBSTANCE ABUSE PATTERNS

Quantity of use:

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……..

Frequency, setting (alone, at home, with friends):

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Methods used to obtain and administer the drugs:

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Drug use history (to determine progression or lack thereof) and age of first use:

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Chronological include info on suicidal thoughts

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PAST TREATMENT HISTORY

Number of treatment programs attended
Name of rehab
When
completed
Periods of abstinence:
Reason for relapse:
Use of self-help/support groups/professional resources:

CRIMINAL AND LEGAL HISTORY:
Comprehensive history of the client's criminal history
Previous convictions
Current offence

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FAMILY HISTORY

Family of origin:

Members:

Name	Relationship	Date of birth/age

- Background(Ethnic, social)
- ……
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- Home environment [permissive/strict home, unresolved feelings of anger towards a parent with SUD, self-hatred issues now that they/client has also developed SUD]
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Relationship with parents : (Current and past)

How the service user feels about parents
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……..
Whether parents had a substance use disorder of their own
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…… ……..
Whether parent are handicap, or died whilst the service user was growing up
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Nature of relationship with significant
others:……
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……..

Sibling's use of substances	
Parents' relationship with children	
PERSONAL HISTORY	
Major life events (relocation, divorces, deaths)	
School history	
Early friendships	
Adolescent behavior	
Intimate relationships	
Supportive/problematic relationships	
Gang Affiliation (name of gang, ranking, duration of membership & gang associated wounds/injuries)	
EDUCATIONAL HISTORY: Factors interfering with education? The degree in which it interfered, reasons for leaving the educational system.	
School history	
Tertiary history	

PSYCHIATRIC HISTORY	
Initial symptoms/symptoms not currently of concern	
Prior treatment and response to treatment	
Other psychiatric disorders that have been treated	
FAMILY PSYCHIATRIC HISTORY (first- and second degree generations)	
Mental illnesses	
Suicides	
Substance abuse	

CURRENT HOME CIRCUMSTANCES (current nature of relationship with family/significant others)

Name	Relationship	Date of birth/age

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INDIVIDUAL DEVELOPMENT PLAN

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Detailed evaluation……

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Recommendation………
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Report compiled by: …….. **Date**: ……..

Report approved by supervisor: ……. **Date**: ……..

Checklist

ID	
Medical report	
IDP	
Voluntary contract	