APPLICATION FORM FOR MOTHWA HAVEN OLD AGE HOME
PRETORIA

PLEASE PRINT ALL INFORMATION BELOW
PLEASE ATTACH A COPY OF APPLICANT'S ID AND THREE (3) MONTH'S BANK STATEMENTS

PERSONAL DETAILS OF APPLICANT

1.	DATE OF APPLICATION:
2.	SURNAME:
3.	FULL NAMES:
4.	ID NUMBER:
5.	DATE OF BIRTH:
6.	GENDER: MALE FEMALE
7.	PRESENT RESIDENTIAL ADDRESS:
8.	MARITAL STATUS:
	IF MARRIED: NAME & ADDRESS OF SPOUSE:
9.	OCCUPATION / PREVIOUS OCCUPATION:
10.	HOME LANGUAGE
11.	CHURCH DENOMINATION & CONGREGATION:
12.	DOCTOR: NAME & TELEPHONE NO.:
13.	PHARMACY: NAME & TELEPHONE NO.:
14.	MEDICAL AID: NAME & MEMBER NO.:
15.	PENSION: NAME & MEMBER NO.:
16.	FUNERAL SOCIETY / BURIAL FUND: NAME & NO.:
17.	WILL: WITH WHOM IS IT LODGED:
18.	LIST OF FURNITURE TO BE BROUGHT INTO HAVEN ON ADMISSION:

ADDRESS: **353 BOOYSENS STREET** **TEL. NO.: 012-335-0882**
ELOFFSDAL **FAX TO EMAIL: 086-645-4224**
PRETORIA 0084

REGISTRATION NO.: **001-091-NPO / VAT REGISTRATION NO.: 4920130319**

MANAGER: **MRS Y Mc MASTER**

INFORMATION OF NEXT - OF - KIN

NAME OF APPLICANT:

CONTACT PERSON:

RELATIONSHIP:
NAME:
TELEPHONE NO.:
CELL PHONE NO.:
E-MAIL ADDRESS:
RESIDENTIAL ADDRESS:
POSTAL ADDRESS:

OTHER FAMILY MEMBERS:

NAME	TELEPHONE NO.	RELATIONSHIP

MOTHWA HAVEN MEDICAL CERTIFICATE

(TO BE COMPLETED BY MEDICAL DOCTOR)

PLEASE ATTACH AN ORIGINAL PRESCRIPTION FOR CURRENT MEDICATION

NAME OF APPLICANT:	
DATE OF BIRTH:	GENDER:

1.	DIAGNOSIS:

2.	PHYSICAL OBSERVATIONS:	
	WEIGHT:	HEIGHT:

3.	DEPENDANCY:	
	DOES APPLICANT NEED ASSISTANCE WITH:	
	DRESSING:	EATING:
	BATHING:	TOILET:
	BEDMAKING:	OTHER:

4.	CARDIOVASCULAR SYSTEM:	
	BLOOD PRESSURE:	PULSE:
	PACEMAKER:	OTHER:

5.	RESPIRATORY SYSTEM:	
	RATE:	OTHER:

6.	DIGESTIVE SYSTEM:	
	APPETITE:	ULCERS:
	DIET:	OTHER:

7.	UROGENITAL SYSTEM:	
	INCONTINENCE:	OTHER:

8.	CENTRAL NERVOUS SYSTEM	
	SIGHT:	HEARING:
	DIZZINESS:	TREMOURS:
	OTHER:	

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9.	JOINTS & MUSCLES:	
	STRENGTH:	DEFORMITIES:
	MOBILITY	SPASTICITY
	ARTHRITIS	OTHER

10.	SKIN:	
	COLOUR:	INFECTION:
	RASH:	NEGLECT:
	DEHYDRATION:	PRESSURE SORES:
	OTHER:	

11.	GENERAL COMPLAINTS:	
	TIREDNESS:	INSOMNIA:
	COUGH:	ITCHINESS:
	INFECTION:	OTHER

12.	MENTAL / PSYCHOLOGICAL CONDITION:	
	DISORIENTATION:	FORGETFULNESS:
	AGGRESSION:	PARANOIA
	OTHER	

13.	PREVIOUS ILLNESSES / OPERATIONS:

14.	ALLERGIES:

15.	CURRENT MEDICATION (PLEASE ATTACH CURRENT PRESCRIPTION)

DOCTOR'S SIGNATURE: _____

PRINT NAME: _____

DATE: _____