

For official use

Date received: \_\_\_\_\_

## Application Form

### Soilse – Henrietta Place Programme

Please read this form carefully, answer all questions as best you can, sign the completed form and return it to Soilse. Our address is at the bottom of the form.

Your name: \_\_\_\_\_ Your date of birth: \_\_\_/\_\_\_/\_\_\_

Your home address: \_\_\_\_\_

Your phone no.: \_\_\_\_\_ Your mobile no.: \_\_\_\_\_

#### Who referred you to Soilse?

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone no.: \_\_\_\_\_ Mobile no.: \_\_\_\_\_

Are you on medication prescribed by a doctor? Yes: \_\_\_\_\_ No: \_\_\_\_\_

If yes, please describe and give amount

Methadone	
Valium	
Sleeping tablets	
Anti-depressants	
Anti-psychotics	
Other	

#### Where do you get your medication?

Name of doctor or clinic: \_\_\_\_\_

Address of doctor or clinic: \_\_\_\_\_

Phone number of doctor or clinic: \_\_\_\_\_

Are you taking any medication that is *not* prescribed by a doctor? If yes, please give the amount and how often you take it.



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**Who is your family doctor (GP)? (if different from above)**

Name of family doctor: \_\_\_\_\_

Address of family doctor: \_\_\_\_\_

**Do you have a counsellor?      Yes: \_\_\_\_\_ No: \_\_\_\_\_**

Name of counsellor: \_\_\_\_\_

Address of counsellor: \_\_\_\_\_

Phone number of counsellor: \_\_\_\_\_

**Have you used any of the following drugs in the past two weeks?**

<b>Drug</b>	<b>Amount and how often</b>
Heroin	
Cocaine	
Cannabis	
Alcohol	
Ecstasy or speed	
Tablets	
Other (please describe)	

**Are you willing to stop using drugs before you start in Soilse? Yes: \_\_\_ No: \_\_\_**

**Please sign and date this form.**

\_\_\_\_\_  
**Your signature**

\_\_\_\_\_  
**Today's date**

**Please return this form to:**

Soilse, 1/2 Henrietta Place, Dublin 1  
Ph: (01) 872 4922    Fax: (01) 872 4891  
Email: [soilsehp@hse.ie](mailto:soilsehp@hse.ie)  
Web: [www.soilse.ie](http://www.soilse.ie)

