For official use Date received:_____

Application Form

Soilse Drug-Free 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.: _____

Are you on medication prescribed by a doctor? Yes: _____ No: ____

If yes, please describe

_____

_____

_____

Who prescribes your medication?

Name of doctor: _____

Address of doctor: _____

How long have you been drug-free? _____

Have you completed a residential treatment programme?

Yes: ____ No: ____

When? _____ Where? _____

Are you currently attending a residential treatment centre?

If yes, what is the name of the centre? _____

What is your discharge date? _____

Do you have a counsellor? Yes: _____ No: _____

Name of counsellor: _____

Address of counsellor: _____

Phone no. of counsellor: _____

Please sign and date this form.

_____ _____

Your signature **Today's date**

Please return this form to:

Soilse
Basement Offices
16-22 Green Street
Dublin 7
Ph: (01) 872 4535 Fax: (01) 894 3396
Email: soilse@hse.ie
Web: www.soilse.ie