

**AANSOEK VIR OPNAME /  
APPLICATION FOR ADMISSION**

**SAVF DIE ANKER TEHUIS**  
BRUCE STR 11  
GERMISTON

**011-825-7206**  
**0865937882 (fax)**  
**dieanker.manager@savf.co.za**



**APPLIKANT SE BESONDERHEDE / APPLICANT'S DETAILS**

Van en Voorname  
Surname and First Names .....

Identiteitsnommer  
Identity number ..... Ouderdom  
Age .....

Manlik / Male ..... Vroulik / Female .....

Posadres  
Postal Address .....  
..... Poskode / Postal Code .....

Woonadres  
Address .....  
..... Poskode / Postal Code .....

Telefoonnommers  
Telephone numbers (H) ..... (W) .....  
..... Sel / Cell .....

Huwelikstatus  
Marital Status

Ongetroud Unmarried	Getroud Married	Geskei Divorced	Vervreemd Separated	Wewenaar Weduwee Widowed	Tradisioneel Traditional
------------------------	--------------------	--------------------	------------------------	--------------------------------	-----------------------------

Rede vir aansoek .....

Huistaal  
Home language ..... Kerkverband  
Denomination .....

Werk u? Indien wel, waar?

Watter ure?

Do you have a job? If so, where? ..... Which hours?  
 .....

Is u van plan om vuurwapens aan te hou. JA / NEE Indien ja – lisensie nommer (heg afskrif aan):  
 .....

Voertuig en bestuurderslisensie  
 Motor vehicle and drivers license  
 .....

Mediese fonds  
 Medical aid .....

Nommer  
 Number .....

**MEDIESE TOESTANDE / GESKIEDENIS**  
**MEDICAL SITUATION / HISTORY**

<b>MEDIESE TOESTAND MEDICAL SITUATION</b>	<b>WANNEER GEDIAGNOSEER WHEN DIAGNOSED</b>	<b>IS DIE TOESTAND ONDER BEHEER:JA/NEE IS THE SITUATION UNDER CONTROL:YES/NO</b>	<b>MEDIKASIE IN GEBRUIK MEDICATION IN USE</b>

Testament (Ja / Nee)  
 Will (Yes / No) .....

Waar?  
 Where? .....

Begrafnispolis? (Ja / Nee)  
 Funeral policy? (Yes / No) .....

Polisnommer  
 Policy number .....

Naam van Ondernemer  
 Name of Undertaker .....

Indien geen polis, wie is verantwoordelik vir reëlings en kostes? .....

Wat verkies u / what do you prefer?:

Begrafnis / Burial ..... Verassing / Cremation .....

Verantwoordelike persoon t.o.v. ontruiming van wooneenheid in geval van dood:

Naam van kontakpersoon..... Hoedanigheid .....

**BESONDERHEDE VAN NAASBESTAANDES / DETAILS OF NEXT OF KIN**

<b>NAAM / NAME</b>	<b>ADRES / ADDRESS</b>	<b>TEL NO</b>	<b>VERWANTSKAP RELATION</b>
	Woon / Residential:  Pos / Postal:		
	Woon / Residential:  Pos / Postal:		

	Woon / Residential:		
	Pos / Postal:		

**Toestemming word gegee vir die vervoer van die inwoner, en dat die SAVF of personeel van ..... nie verantwoordelik gehou sal word in geval beserings as gevolg van 'n ongeluk nie. / *Permission are given to transport the resident, and that the SAVF or personnel of ..... will not be held responsible for injuries obtained in the event of an accident.***

Alle inwoners van SAVF Die Anker moet fisies en psigies selfversorgend wees en neem volle verantwoordelikheid vir eie versorging en die neem van medikasie. SAVF Die Anker Bestuur en personeel neem geen verantwoordelikheid vir mediese versorging en uitdeel van medikasie nie.

All residents of SAVF Die Anker must be physical and psychologically self supportive and take full responsibility of caring for themselves and taking medication. SAVF Die Anker management and personnel can not and will not be held responsible for any medical care and distribution of medication.

### **VERKLARING/DECLARATION.**

Ek, die ondergetekende, doen hiermee aansoek vir opname in SAVF Die Anker en verklaar dat;/ I, the undersigned, do hereby apply for admission to SAVF Die Anker and declare;

- a) Besonderhede soos deur my verstrekk waar en juis is/ Particulars furnished by me are true and correct.
- b) Ek is vertrouwd met die voorwaardes vir opname en lê my daarby neer/ I am familiar with the terms and conditions of admission and I acquiesce in them.

-----  
DATUM/DATE

-----  
HANDTEKENING/SIGNATURE

MEDICAL REPORT IN RESPECT OF AN APPLICANT FOR ADMISSION TO A SAVF HOME

Full name: \_\_\_\_\_

Complaints of applicant (history, symptoms and previous treatment. Also state hospital where treated). \_\_\_\_\_

**GENERAL EXAMINATION:**

General physical and nutritional state: \_\_\_\_\_

Respiratory system: \_\_\_\_\_

Cardiovascular system: \_\_\_\_\_

Blood pressure (to be taken in all cases): \_\_\_\_\_

Genito-urinary system (urine to be tested in all cases): \_\_\_\_\_

Digestive and other abdominal systems: \_\_\_\_\_

Muscular and skeletal system (state defects): \_\_\_\_\_

Central nervous system (in epilepsy state in particular type, severity, frequency of attacks and response to treatment): \_\_\_\_\_

Mental condition (including mental deficiency) state in particular type of defect and mental age, possible and whether institutional care is advisable: \_\_\_\_\_

Is applicant free from infections and contagious diseases? \_\_\_\_\_

Any other condition not included in classification above: \_\_\_\_\_

Is applicant permanently bedridden? \_\_\_\_\_

Is applicant without self-control? \_\_\_\_\_

Can applicant be satisfactorily cared for by and unqualified attendant? \_\_\_\_\_

Does applicant require assistance in respect of mobility, dressing or undressing? \_\_\_\_\_

Does applicant require constant and prolonged assistance regarding to mobility, dressing or undressing, feeding and personal hygiene? \_\_\_\_\_

Will further medical/surgical treatment improve or cure the disabilities described above? If so, state clearly what treatment is recommended: \_\_\_\_\_

Present medication: \_\_\_\_\_

Any further medication: \_\_\_\_\_

General remarks: \_\_\_\_\_

PLACE: \_\_\_\_\_ DATE: \_\_\_\_\_

PRACTITIONER: \_\_\_\_\_