REGISTRATION FORM: PSYCHOLOGICAL SERVICES  
STRICTLY CONFIDENTIAL

|  |
| --- |
| Guidelines for using this form |
| 1. This form is for completion by a UCT student wanting to access psychological services at the DSA Student Wellness Service (SWS) for the first time. 2. Please email the completed form to [sws@uct.ac.za](mailto:sws@uct.ac.za?subject=Confidential:%20DSA-SWS-ADM009:%20Registration%20form:%20Medical%20services). |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| SECTION A: STUDENT APPLICANT DETAILS (Note: To be completed by the student) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Student Title, Name and Surname | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Student Number |  | | |  |  | |  |  | | |  |  | | |  | |  | | | Age | | | |  | | | | Date of Birth | | | | | | | | |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | | D | D | M | M | Y | Y | Y | Y | | | |  | |  |  | |  |  |  |  |
| Faculty |  | | | | | | | | | | | | | | | | | | | Course of Study | | | | | | | | | | | |  | | | | | | | | | | | | | | | |
| Year of Study |  | | | | | | | | | | | | | | | | | | | First Year of Registration | | | | | | | | | | | | | | |  | | | | | | | | | | | | |
| Sex (please tick one) | | | | | | Male | | | | | | |  | | | | | | | | | Female | | | | | | |  | | | | | | | | | Trans | | | | |  | | | | |
| Telephone No. | | | | | | Term No. | | | | | | |  | | | | | | | | | | | | | | | | | Cell No. | | | | | | |  | | | | | | | | | | |
| UCT Email Address | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| University Term / Physical Address (in Cape Town) | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Next of Kin / Person to be contacted in an emergency | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Next of Kin Contact No. | | | | | |  | | | | | | | | | | | | | | | | Next of Kin Relationship | | | | | | | | | | | | | | | |  | | | | | | | | | |
| Do you receive financial aid from NSFAS?  (Note: Bursaries and scholarships are not included.) | | | | | | | | | | | | | | | | | | Yes | | | | |  | | | No | | | |  | | |  | | | | | | | | | | | | | | |
| If yes, please send a copy of the letter to [sws@uct.ac.za](mailto:sws@uct.ac.za) so that consultation fees can be waivered | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Are you on Medical Aid? | | | | | | Yes | | | |  | | | No | | |  | | | | | Name of Medical Aid | | | | | | | | | | | | |  | | | | | | | | | | | | | |
| Membership No. | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Main Member | | Name and Surname | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | Contact No. | | | | | | | | | |  | | | | | | |
| We continually strive to improve our services to students by way of research, advocacy or case management. To this end we might need to use some of the information in a confidential and anonymous way. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Do you consent to this? | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| SECTION B: STUDENT AGREEMENT (Note: To be completed by the student) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| I understand that I am personally responsible for all consultation costs incurred at Student Wellness Service. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Student Signature | | |  | | | | | | | | | | | | | | | | | | | | | | Date | | | | | | |  | | | | | | | | | | | | | | | |
| FOR OFFICE USE ONLY | | | | | | Capture Date | | | | | | | |  | | | | | | | | | | | | | Admin Signature | | | | | | | | | | | | |  | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |