Republic of the Philippines
Office of the President
DANGEROUS DRUGS BOARD
3/F, DDB-PDEA Bldg, NIA Northsite Road, National Government Center
Brgy Pinyahan, Quezon City

DDB IDADIN Form 1 - 06
Name of Hospital: _____
Region: _____
Province: _____
City/Municipality: _____

(To be submitted by Public and Private Hospitals and Detoxification Centers)

For the _____ Quarter of 200____

GENERAL DATA:

1. Name of Patient:

_____
Family Name First Name Middle Name

2. City Address:

_____
_____
_____
Provincial Address
_____
_____

3. Date of birth:

_____
Day Month Year

4. Demographic Data:

4.1 Gender: [ ] Male [ ] Female
4.2 Age: _____
4.3 Civil Status:
[ ] Single [ ] Separated
[ ] Married [ ] Live-in
[ ] Widow/er
4.4 Occupation: _____

5. Name of Father:

_____
Name of Mother:
_____

6. Date of Emergency Treatment/Admission to Hospital:

_____
Day Month Year

7. Reason for Present Confinement:
[ ] Acute Intoxication
[ ] Chronic Abuse
[ ] Drug Dependence
[ ] Adverse Reaction
[ ] Suicide Attempts
[ ] Others, specify:
_____

8. Drug/s/Substance Abuse That Cause Hospital Admission/s:

Substance/Drug/s	Year			Route of Use
	First Use	Last Use	Current Use	
Methamphetamine				
Cannabis				
Ecstasy				
Benzodiazepines				
Other drug type:				

9. Record of Hospital Admision In Relation to substance abuse:

Number of Times:	Date	Name/Address of Hospital
[ ] 1st time		
[ ] 2nd time		
[ ] 3rd time		
[ ] Others, specify		

10. History of Drug Use/Rehabilitation (If Applicable)
[ ] None
[ ] Yes, how many times? _____
Specify drug treatment Center:
_____

10.1 Reasons for taking drug/substance
[ ] Curiosity
[ ] Control of hunger pangs
[ ] Peer pressures
[ ] To get high
[ ] Others, specify:
_____

11. History of Psychiatric Confinement (if applicable)
[ ] None
[ ] Yes, how many times? _____
Specify hospital/clinic:
_____

12. Outcome:
[ ] Medical Discharge
[ ] Hospitalization
[ ] Refer to rehabilitation/psychiatric confinement
[ ] Discharge against medical advice
[ ] Escaped
[ ] Death
[ ] Others, specify

Certified True and Correct:

_____
Parent/Guardian/Spouse
(Signature Over Printed Name)
(Please Indicate Relation with Patient)