



**SECTION E: SOCIAL INFORMATION**

Client is aware and consented to this referral being made:  Yes  No (Specify: \_\_\_\_\_)

Client's family has been informed about the referral:  Yes  No (Specify: \_\_\_\_\_)

Client is known to other community service:  NA  Yes (Specify: \_\_\_\_\_)

Client is known to MSW/Case Manager/Care Coordinator:  NA  Yes (Name : \_\_\_\_\_)  
(Contact : \_\_\_\_\_)

Contact Person : \_\_\_\_\_ Relationship with client: \_\_\_\_\_

Contact Address : \_\_\_\_\_ S(\_\_\_\_\_)

Contact No.: \_\_\_\_\_ (H) \_\_\_\_\_ (O) \_\_\_\_\_ (H/P)

Any other recommended services? (Specify: \_\_\_\_\_)

**SECTION F: FINANCIAL SUPPORT**

On Public Assistance?  No  Yes (PA Ref No: \_\_\_\_\_)

Is means test completed?  Yes  0%  25%  50%  75%  
 No  Not eligible  Not applying

Current financial support: \_\_\_\_\_

**SECTION G: DECLARATION**

- I declare to the best of my knowledge and belief that the particulars furnished by me and/ or the care person are true and correct.
- I understand that I am obliged to abide by the regulations/ agreement laid down by the organization/institution involved.
- I have been informed that in the course of processing the application, it may be necessary for the Referring Agency to disclose/ transfer relevant information pertaining to me/my household to other agencies.
- I understand that the disclosure of such information is necessary to facilitate the application for the Centre. I also hereby do give my consent for the release/ disclosure of such information to the relevant bodies to facilitate consideration of the application.

Name	Signature of Client / Caregiver	Relationship	Date
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**SECTION H : FUNCTIONAL INFORMATION**

<p><b>Balance:</b></p> <input type="checkbox"/> Normal <input type="checkbox"/> Difficult to stand up <input type="checkbox"/> Dizziness <input type="checkbox"/> Unsteady gait	<p><b>Number of Falls (within 3 months):</b></p> <input type="checkbox"/> No fall <input type="checkbox"/> 1 fall <input type="checkbox"/> > 2 falls	<p><b>Vision:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>Hearing:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p><b>Dyspnea:</b></p> <input type="checkbox"/> No Symptom <input type="checkbox"/> Strenuous activities <input type="checkbox"/> Daily activities <input type="checkbox"/> At rest	<p><b>Mental Status:</b></p> <input type="checkbox"/> Rational <input type="checkbox"/> Unable to respond <input type="checkbox"/> Confused <input type="checkbox"/> Others : _____	<p><b>Mobility:</b></p> <input type="checkbox"/> Wheelchair <input type="checkbox"/> Bedbound <input type="checkbox"/> Ambulant/walking - Walking aid <input type="checkbox"/> N/A <input type="checkbox"/> Walking frame <input type="checkbox"/> Quadstick <input type="checkbox"/> Walking stick/Umbrella <input type="checkbox"/> Others
<p><b>Respiratory Care:</b></p> <input type="checkbox"/> Oxygen Therapy <input type="checkbox"/> Suction <input type="checkbox"/> Trachy care <input type="checkbox"/> BIPAP <input type="checkbox"/> Others: _____	<p><b>Bowel Management:</b></p> <input type="checkbox"/> Continent <input type="checkbox"/> Colostomy <input type="checkbox"/> Diapers <input type="checkbox"/> Ileostomy <input type="checkbox"/> Others: _____	<p><b>Assistance level required for wheelchair or ambulant/walking:</b></p> <input type="checkbox"/> Independent <input type="checkbox"/> Min Assist <input type="checkbox"/> Moderate Assist <input type="checkbox"/> Max Assist/Dependent
	<p><b>Wound Care:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	

Activity	Independent	Minimal Assistance	Moderate Assistance	Max assist / Dependent	Specify:
Transferring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Grooming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Toileting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Diapers <input type="checkbox"/> Urinary catheter
Feeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Oral <input type="checkbox"/> NG Tube <input type="checkbox"/> PEG

**SECTION I : ENVIRONMENT**

<p><b>Lift landing:</b></p> <input type="checkbox"/> Yes <input type="checkbox"/> No	<p><b>Living near Food Amenities:</b></p> <input type="checkbox"/> Yes <input type="checkbox"/> No	<p><b>Steps from house to corridor:</b></p> <input type="checkbox"/> Yes <input type="checkbox"/> No
<p><b>Ability to navigate Transport:</b></p> <input type="checkbox"/> Yes <input type="checkbox"/> No specify: _____	<p><b>Require Home modification:</b></p> <input type="checkbox"/> Yes, specify: _____ <input type="checkbox"/> No	<p><b>Access to public transport:</b></p> <input type="checkbox"/> Walking distance to bus stop / MRT <input type="checkbox"/> Transfer of bus/ MRT required

Name of Client: \_\_\_\_\_

NRIC: \_\_\_\_\_

**CENTRE BASED - SECTION J to O**

**SECTION J: PREFERENCES (For all Day Care Referrals only)**

<b>Services Required:</b> <input type="checkbox"/> Trial Rehab <input type="checkbox"/> Rehab <input type="checkbox"/> Maintenance Exercise <input type="checkbox"/> Others, specify: _____	<b>Activity Tolerance level:</b> <input type="checkbox"/> Poor (0 to 45mins) <input type="checkbox"/> Fair (15 to 45mins) <input type="checkbox"/> Good (> 45mins)	<b>Location:</b> <input type="checkbox"/> Preferred: _____ <input type="checkbox"/> Preferred Centre: _____
<b>Duration:</b> <input type="checkbox"/> Half day <input type="checkbox"/> Full day <input type="checkbox"/> Others, specify: _____	<b>Escort required bringing client to wait for transport?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA (Client can manage)	<b>Diet:</b> <input type="checkbox"/> Yes, specify: _____ <input type="checkbox"/> No
		<b>Transport Required:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No

**CENTRE BASED SERVICES REFERRAL ONLY – SOCIAL DAY CARE / DEMENTIA DAY CARE / DAY REHABILITATION**

**SECTION K: MEDICAL INFORMATION (If inpatient discharge summary is attached, please indicate 'see attached'.)**

**Summary of Medical Condition / Problem:**

\_\_\_\_\_

**\*Active Infectious Disease:**       Yes (specify) \_\_\_\_\_       No

**\*Any Food Allergies**       Yes (specify) \_\_\_\_\_       No

**Summary of Investigation & Management:**

\_\_\_\_\_

**Medication / Dosage / Frequency:**

\_\_\_\_\_

**\*Drug Allergies**       Yes (specify) \_\_\_\_\_       No

**SECTION L: FOR DAY REHABILITATION CENTRE REFERRAL ONLY (To be completed by Medical Doctor)**

Is client fit to undergo rehabilitation?       Yes       No       Trial only

Does client require rehabilitation?       Yes       No

Are there any precautions to be taken or conditions that require closer monitoring?

Yes (specify) \_\_\_\_\_       No       NA

**SECTION M: DEMENTIA DAY CARE (DDC) (To be completed for DDC referral only)\***

**\*Please Note: Clients referred to DDC centres must be diagnosed by a qualified medical practitioner to be suffering from dementia**

Type of Dementia:       Multi-Infract/Vascular       Alzheimer's Disease       Others: \_\_\_\_\_

Dementia Follow-up:       Yes (Pls provide details)       No

Dr's Name: \_\_\_\_\_      Designation: \_\_\_\_\_      Institution: \_\_\_\_\_

Next TCU date (if any): \_\_\_\_\_      Clinic/Hospital: \_\_\_\_\_

**Cognitive & Behavioral Symptoms (please tick if present & provide details)**

Paranoid & Delusional Ideation      : \_\_\_\_\_

Hallucination      : \_\_\_\_\_

Day/Night Disturbances      : \_\_\_\_\_

Anxieties & Phobia      : \_\_\_\_\_

<b>Activity Disturbances:</b> <input type="checkbox"/> Wandering <input type="checkbox"/> Purposeless Activity <input type="checkbox"/> Inappropriate Activity	<b>Aggressiveness:</b> <input type="checkbox"/> Verbal Outburst <input type="checkbox"/> Physical threats&/or violence <input type="checkbox"/> Agitation	<b>Affective Disturbances:</b> <input type="checkbox"/> Tearfulness <input type="checkbox"/> Depressed Mood <input type="checkbox"/> Other: _____
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**Additional Remarks / Details:**

\_\_\_\_\_

**SECTION O: PARTICULARS OF DOCTOR COMPLETING THIS PAGE (For application of Day Care Services)**

Name:	Signature:
Hospital/Unit/Designation/MCR:	Date of assessment:

Name of Client: \_\_\_\_\_ NRIC: \_\_\_\_\_

**HOME CARE – SECTION P to T**

**SECTION P: HOME CARE REFERRAL (Only)**

**Home Medical Service:**

- Follow-up of Chronic illness / prescription of medication
- Others (Specify): \_\_\_\_\_

**Home Nursing Service (Attach Wound Chart):**

- Procedures: (Please proceed to Section Q)
- Health Education / Monitoring of BP / Blood Glucose
- Caregiver Training (Specify): \_\_\_\_\_
- Others (Specify): \_\_\_\_\_

**Home Therapy Service (Attach Therapist Report):**

- Physiotherapy
- ADL / IADL Training
- Home Environment Assessment & Home Care Equipment Training
- Caregiver Training (Specify): \_\_\_\_\_
- Others (Specify): \_\_\_\_\_

**SECTION Q: MEDICAL INFORMATION (If inpatient discharge summary is attached, please indicate 'see attached'.)**

**Summary of Medical Condition / Problem:**

\*Active Infectious Disease:       Yes (specify) \_\_\_\_\_       No

\*Any Food Allergies                       Yes (specify) \_\_\_\_\_       No

**Summary of Investigation & Management:**

**Medication / Dosage / Frequency:**

\*Drug Allergies                               Yes (specify) \_\_\_\_\_       No

**SECTION R: PROCEDURES (For Home Nursing Referral Only)**

**Feeding Tube:**

- Ryle's Tube
- Flexiflo
- Size : \_\_\_\_\_
- Due for change: \_\_\_\_\_

**Urinary Catheter:**

- Urethra
- Supra pubic
- Size : \_\_\_\_\_
- Due for change : \_\_\_\_\_

**Wound:**

- Site: \_\_\_\_\_
- Dressing Type: \_\_\_\_\_
- Freq of Change: \_\_\_\_\_
- Date of last Change: \_\_\_\_\_

**Stoma:**

- Tracheotomy                               PEG     Ileostomy
- Dressing due for change: \_\_\_\_\_      Dressing due for change: \_\_\_\_\_      Dressing due for change: \_\_\_\_\_

**Injection (IM/SC):**

- Type of injection: \_\_\_\_\_      Dosage: \_\_\_\_\_      Frequency: \_\_\_\_\_
- Date of last change: \_\_\_\_\_      Others: \_\_\_\_\_

**SECTION S: HOME THERAPY SERVICE**

**Activity Tolerance:**       Poor (<15 mins)       Fair (15 to 45 mins)       Good (>45 mins)

**Respiratory Care:**

- NA                       Oxygen Therapy       Suction                       BIPAP                       Trachy care                       Others

**SECTION T: PARTICULARS OF DOCTOR COMPLETING THIS PAGE (For application of Home Care Services)**

Name:	Signature:
Hospital/Unit/Designation/MCR:	Date of assessment:

Name of Client: \_\_\_\_\_

NRIC: \_\_\_\_\_