

Confidential

REFERRAL FORM

Please attach Annex A–Social Report and Annex B-Medical Information.

For children with special needs aged 0 to 6 years recommended for early intervention and support.

1. CHILD'S PARTICULARS

Name: _____ Gender: *Male / Female
Birth Certificate Number: _____ D.O.B: _____
Religion: _____ Citizenship: *Singapore Citizen / PR / Others
Home Address: _____ S()
Home Tel No: _____

2. FAMILY PARTICULARS

Name of Father: _____
NRIC Number: _____ D.O.B: _____
Citizenship : *Singapore Citizen / PR / Others
Educational Level: _____ Main Language Spoken: _____
Occupation: _____ Gross Monthly Income: _____
Tel No: _____ (Office) _____ (H/P)
Email: _____

Name of Mother: _____
NRIC Number: _____ D.O.B: _____
Citizenship: *Singapore Citizen/ PR/ Others
Educational Level: _____ Main Language Spoken: _____
Occupation: _____ Gross Monthly Income: _____
Tel No: _____ (Office) _____ (H/P)
Email: _____

* Please delete accordingly

**Annex A
SOCIAL REPORT**

Name: _____ Gender: *Male / Female

Birth Certificate Number: _____ D.O.B: _____ Age: _____

GENOGRAM Draw a genogram of the immediate family and significant family members.
(Include the age, occupation and other important information about the person.)

(Only for EIPIC referral)

1. FAMILY BACKGROUND:

Family Size: (only for EIPIC referral)

- Nuclear family of 3. Patient is the only child
- Nuclear family of _____. Patient has _____ sibling(s)
- Family has extended family living with them, pls indicate: _____
- Parents have a foreign domestic helper

Accommodation:

- The family is living in a ____-room HDB flat
- The family is living in a condominium / private property*
- The family is renting a ____ - room HDB / private housing*

Childcare Support:

Main caregiver

- Mother
- Domestic helper
- Maternal grandparents
- Paternal grandparents
- Others, pls indicate: _____

Social Support Network

- Parents have a lot of support from paternal / maternal grandparents*
- Parents have some childcare support from extended family as and when required
- Parents have very little or no support from extended families
- Parents have support from friends / neighbours*
- Others: _____

2. PARENTS' / CAREGIVER'S AWARENESS AND ACCEPTANCE OF DISABILITY:

Parents' / Caregiver's Acceptance of Child's Condition

- Parents / Caregiver are still in denial of their child's condition*
- Father is coming to terms with child's condition but mother is still in denial
- Mother is coming to terms with child's condition but father is still in denial
- Parents / Caregiver are coming to terms with child's condition*
- Parents / Caregiver have accepted child's condition well*
- Others: _____

Parents' / Caregiver's Understanding of Child's Condition

- Parents have some understanding of child's condition
- Parents do not have a clear understanding of child's condition
- Father / Mother agrees with the suspected / confirmed diagnosis*
- Parents agree / disagree with the suspected / confirmed diagnosis*
- Father / Mother disagrees with the suspected / confirmed diagnosis*
- Caregiver agrees / disagrees with the suspected / confirmed diagnosis*
- Parents / Caregiver have had a lot of information and resource knowledge on child's diagnosis*

Parents' / Caregiver's Awareness of Child's Condition

- Parents / Caregiver noticed some signs of delayed development when child was 1 – 2 years old and decided to bring child for a check-up*
- Parents / Caregiver noticed some signs of delayed development but wanted to monitor further*
- Parents / Caregiver noticed some signs of delayed development but thought that the child would "outgrow" this if given more time*
- Parents were alerted by childcare / preschool teacher*
- Parents were alerted by an extended family member / friend / neighbour*

Parents' / Caregiver's Motivation in Helping to Facilitate Child's Development

- Parents / Caregiver is / are keen to help the child to overcome his / her difficulties*
- Parents / Caregiver feel(s) helpless due to lack of skills / knowledge to facilitate child's development*
- Father is very involved / uninvolved in the care and management of the child*
- Mother is very involved / uninvolved in the care and management of the child*

3. COMMUNITY INTERVENTIONS:

(List Community Resources / VWOs who are assisting child / family):

- Patient is now attending a daily half-day / full-day childcare programme with*

Patient is attending private intervention sessions with _____

Patient is attending private speech therapy / occupational therapy sessions with*

Family is now receiving financial aid / counselling from an external agency,*

4. SOCIAL ASSESSMENT:

Parents seem to be coming to terms with child's condition

Parents seem to be in denial

Parents appear to be open about placing child in the EIPIC Programme

The family has financial difficulties and parents are concerned about the affordability of EIPIC Programme

Others: _____

5. RECOMMENDATIONS:

(Only for EIPIC referral)

Parents have requested for financial aid / subsidy for the monthly EIPIC fees

Parents are anxious about the long waiting period and have requested for child to be placed in an EIPIC Centre as soon as possible

Others: _____

Report Prepared by:

Name: _____

Signature: _____

Designation: _____

Organisation: _____

Contact No.: _____

(FAX): _____

Email: _____

Date: _____

**please circle*

**Annex B
MEDICAL INFORMATION**

1. DIAGNOSIS

Principal Diagnosis: *Confirmed* *Suspected*

<input type="checkbox"/> ASD	<input type="checkbox"/> GDD ¹	<input type="checkbox"/> Physical Disability
<input type="checkbox"/> ADHD	<input type="checkbox"/> Hearing impairment	<input type="checkbox"/> Speech & language
<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> Intellectual disability	<input type="checkbox"/> Visual impairment
<input type="checkbox"/> Dyslexia		

Other diagnosis: _____

Cause: Unknown Specify: _____

Level of functioning:

Mild (D) Mild-Moderate (C) Moderate-Severe (B) Severe (A)

2. HISTORY

Birth and Postnatal History: (Only for EIPIC referral)

Developmental milestones: (Only for EIPIC referral)

Delayed since: *infancy* *early childhood*

Normal initially, but delayed since sustaining cerebral injury at _____ (age)

Developmental regression

Others _____

Information not available

Medical History:

None

Epilepsy

Swallowing dysfunction, on: *tubefeeding* *gastrostomy* *special diet*

Gastroesophageal reflux

Failure to thrive

Reactive airway disease / asthma

Involuntary movements, specify _____

Others _____

Other physical abnormalities (*dysmorphic features*):

Yes, specify _____

No

Current Medications (State doses):

Allergies (Drugs / food, if any):

¹ Global Developmental Delay (GDD) is defined as significant delay in two or more developmental domains.

Family history of any relevance to disability:

3. CURRENT STATUS

PHYSICAL ASSESSMENT (Only for EIPIC referral)		Percentiles
Weight		
Height		
Head circumference		

HEARING ASSESSMENT (Only for EIPIC referral)

- Suspected hearing impairment
- Grossly normal: Responds to sound Understands verbal command
- Hearing test:
 - Not done
 - Pending. Date: _____
- Date performed: _____
- Instrument/ test:
 - Otoacoustic Emission (OAE)*
 - Automated Auditory Brainstem Response (AABR)*
 - Brainstem Auditory Evoked Response (BAER)*
 - Others:* _____
- Normal
- Abnormal, specify: _____
- Hearing aids

VISUAL ASSESSMENT (Only for EIPIC referral)

- Suspected visual impairment
- Grossly normal i.e. Visually fixates and follows in all directions fairly well
- Visual assessment:
 - Not done
 - Pending. Date: _____
- Date performed: _____
- Normal
- Abnormal, specify:
 - Myopia*
 - Hypermetropia*
 - Astigmatism*
 - Others:* _____
- Visual aids

PSYCHOLOGICAL ASSESSMENT <i>(Please attach relevant assessments)</i>			
Psychological Assessment	<input type="checkbox"/> Done	<input type="checkbox"/> Not done	<input type="checkbox"/> Pending Date: _____

4. DEVELOPMENTAL STATUS

Gross motor milestones:

- Within normal limits
- Delay: *mild* *moderate* *marked*

Motor tone:

- Within normal limits
- Abnormal, specify:
 - Diffuse hypotonia*
 - Axial hypotonia with spasticity of the limbs*
 - Hemiplegia*
 - Diplegia*
 - Quadriplegia*
 - Double hemiplegia*
 - Others:* _____

Ambulatory status *(may tick more than one box)*:

For all children:

- Totally non-ambulatory i.e. bedridden or wheelchair bound
- Totally dependent on others for activities of daily living
- Able to move with assistive devices (walker, rollator, wheelchair etc)
- Independent gait: *normal gait* *abnormal gait, specify:* _____

For infants / toddler:

- Able to roll over
- Able to sit independently
- Able to crawl
- Able to stand with support and / but not cruise
- Others: _____

Fine motor skills:

- Appropriate for age
- Delayed, specify: _____
- Information not available

Language & Communication:

- Mute
- Vocalisation, cooing
- Babbling, no intelligible words
- Single words mainly (including papa, mama)
- 2-4 words sentences
- Talk in complete sentences
- Able to request
- Quality of speech, if available

- Poor communicative intent

- Use of gestures
- Others: _____
- Information not available
- Unable to assess

Social Behavioural Skills & Observations:

- Within normal limits
- Poor eye contact/joint attention
- Poor social interaction
- Hyperactive
- Passive
- Aggressive/self injurious behaviour

Other behavioural observations, specify: _____

Cognitive function:

- Fairly appropriate for age
- Mild to moderate cognitive delay
- Severe cognitive delay – require assistance from others in activities of daily life
- Unable to assess

Other remarks:

5. RECOMMENDATION AND REFERRAL

This child is recommended for the following service type (pls tick):

- VWO-based therapy
Short term therapy sessions at VWO centres or child's homes. May be suitable for mild to severe levels of functioning.
- Mainstream preschool with additional support
May be suitable for mild to mild-moderate levels of functioning.
- Early Intervention in dedicated centre
Centre-based EIPIC programme. May be suitable for moderate-severe to severe levels of functioning.
Please indicate type of programme recommended:
 - a) Early Intervention for Autism Spectrum Disorder
 - b) Early Intervention for Global Developmental Delay
 - c) Early Intervention for other disabilities, specify: _____

Remarks / Comments: _____

Referred to (Provide service type and programme name):

Name of Doctor / Staff	:	
Hospital / Clinic / Department	:	
Contact Number	:	
E-mail	:	
Date of Referral	:	
Signature & Stamp	:	