REFERRAL TO PRODUCTION WORKSHOP

FOR PERSONS WITH DISABILITIES

This referral can be used commonly to refer a client to a Production Workshop.

Part I: SCREENING

1. APPLICANT'S PARTICULARS

Name of Client: ______________________ Identity No.: ________________

Citizenship: ____________ Date of Birth: ____________ Age: ____ Gender: M / F

Address: ________________________________ Singapore __________

Tel No.: __________(O) __________(H/P) Fax: ________ Email: ______________

Disability: ❒ Intellectual ❒ Physical ❒ Autism ❒ Hearing ❒ Visual ❒ Others, pl specify: ________
❒ Multiple, please specify: ________________❒ Diagnosis______________

Type of Referral: ❒ Self ❒ Referred by MP ❒ VWO, please specify: ____________________

❒Referred by others, please specify: ____________________________

2. PRIMARY CAREGIVER'S PARTICULARS

Name: ______________________ Relationship to Applicant: ________________

Identity No.: __________ Citizenship: ______ Date of Birth: ______ Age: ____ Gender: M / F

Address (if different from applicant):________________________Singapore________

Tel No.: __________ (O) __________ (H/P) Fax: ________ Email: ______________

3. REFERRING AGENCY

Referring Agency: ______________________ Date of Referral: ____________

Referring Person: ______________________ Designation: ________________

Tel No.: __________ (O) Fax: ________ Email: __________________

Reason for referral: ____

This referral has been received by ______________________ on ____________

Name / Designation Date / Time

4. Recommendations for Referral

1. Does the applicant meet the eligibility criteria set for the programme?[1] ❒Yes ❒ No
2. Is the referred DAC nearest to applicant's residential address? ❒ Yes ❒ No

   If not, please state reason for choice: ____

   Transport needs: ❒ Yes ❒ No specify: ______________________________________

   (Transport with hydraulic lift / Stair crawl/ Mobility Aides / Travels Independently)

   Stairs to home? ❒ Yes ❒ No
3. Is there vacancy immediately available for admission? ❒ Yes ❒ No

   (If not, please state expected MM/YYYY of availability: ________________)

[1] Eligibility refers to basic criteria such as age, disability type, citizenship, etc spelt out in the prevailing service models of the programme

PART II: ASSESSMENT

1. EDUCATIONAL HISTORY

Name of School/Institution	Qualifications	Year Graduated

* If there is insufficient space, please write on a separate paper.

2. EMPLOYMENT HISTORY

Period of Employment		Position Held	Name of Company	Reasons for leaving
From	To			

3 FAMILY STATUS (please tick☑)

- ❐ Single and alone
- ❐ Family (Parent / Spouse / Children/ Siblings) Please circle the relevant one
- ❐ Single but has relatives (including siblings living apart)
- ❐ Others (Specify) ____________________________

4. CURRENT LIVING ARRANGEMENT (please tick ☑)

- ❐ Living alone
- ❐ Sharing flat
- ❐ Living with friend
- ❐ Living with employer/ex-employer
- ❐ Living with spouse
- ❐ Others (specify) ___________________
- ❐ Living with child/children
- ❐ Living with grandchildren
- ❐ Living with parent (s)
- ❐ Living with relatives
- ❐ Living in Institution (specify) ______
- ❐

5. MEANS OF SUBSISTENCE (main supports to be indicated by☑)

- ❐ Casual work (specify)

  Place of work: _______________________ monthly income:_________________

- ❐ Savings: $_____________
- ❐ CPF Savings: $_________
- ❐ Insurance: $____________
- ❐ Pension: $____________
- ❐ Supported by friend/ex-employer
- ❐ Supported by family
- ❐ Supported by relative

6. Application Form for Government Subsidy for Day Activity Centre

❒ The applicant is on Public Assistance (Ref No: PA__________________)

❒ The applicant is on MFEC (Ref No: __________________)

a) Ownership of Property by applicant / spouse

❒ No (Ref No: PA__________________)

❒ Yes, HDB 3 Rooms, No. of occupants ____________________ (excluding applicant)

❒ Yes, HDB 4-5 Rooms, No. of occupants ____________________ (excluding applicant)

❒ Yes, HDB Multi-generation, No. of occupants ____________________ (excluding applicant)

❒ Yes, Private Property

c) Applicant and/or spouse savings, CPF, shares and other resources as listed below:

TYPE	APPLICANT'S	APPLICANT'S SPOUSE
Savings ($)		
CPF($)		
Medisave ($)		
Unit Trusts		
Shares		

d) ❒ All the particulars of the applicant's family members have been included in Family Members Particulars.

DECLARATION

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

______________________________ ______________________________

RTP/ Signature of applicant /or
Person In-charge (NRIC:
Person making the application

Name

______________________________ ______________________________

Relationship / Designation

Date

7. Family Members' Particulars

Name of Immediate family member[2]	Stay with applicant (Y/N)	Relationship to Applicant	NRIC No.	Age	Sex	Marital Status	No of dependents[3]		Occupation	Gross Monthly Income [4]
							Adult	Children[5]		
Qualified Subsidy Rate	75% ☐ 50% ☐ 25% ☐									

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[2] Includes applicants, applicant's spouse, and applicant's parents. Applicant's children and siblings who share the same residence, applicant's children who stay away and have income.

[3] Eligible dependents include spouse and children who do not have an income of those listed in column 1

[4] Refers to gross monthly income, excluding rental and interest income, of applicant and spouse, before deduction for CPF etc. For applicant's parents, all children and siblings staying with applicant, gross income includes all sources of income. Documents for verification – income tax statement, pay slip or statutory declaration for those without pay slip or income tax statement and other supporting documents where applicable

[5] Children below 16 years of age are also considered as 1 headcount wef 1 Jan 2004

8. Social Report

Please attach the typed social report and include the following information on the applicant:

- Client's psychosocial background / issues
- Family support
- Other assistance applicant is receiving
- Reasons for day care
- Social workers recommendation
- Genogram
- Other relevant documents and/or descriptions
- Known / attended to by other VWO
- How much can family pay for fees?

9. Medical History (Please attach Medical Report)

Primary diagnosis: ______________________

- ❒ Asthma / Chronic Cough
- ❒ Congenital / Heart Disease
- ❒ Diabetes Mellitus
- ❒ Epileptic Fits
- ❒ Hypertension
- ❒ Orthopaedic Conditions
- ❒ Skin Disease
- ❒ Tuberculosis
- ❒ Contagious or Infectious Disease ______________________________
- ❒ Past History of Surgery Done______________________
- ❒ Others ______________________

❒ Has No Psychiatric Illness ❒ Has Psychiatric Illness _____________

Present Medication

1. __________________________ 5. __________________________
2. __________________________ 6. __________________________
3. __________________________ 7. __________________________
4. __________________________ 8. __________________________

Drug allergy: ____________________Food allergy: ____________________________

Next Medical Review at (If any): ______________Next Medical Date: ____________

10. ASSESSMENT ON ACTIVITIES OF DAILY LIVING

FUNCTIONAL ASSESSMENT INDEX	SCORE	REMARKS/ACTION
1. AMBULATION/ WHEELCHAIR a) Bed or Chair bound b) Semi-ambulant requires 2 assistants c) Semi-ambulant, using walking aids to move and/ or 1 person to support d) Requires minimal help/ supervision e) Fully mobile with or without aids (e.g. including wheelchair)	 0 3 8 12 15	
2. TRANSFER a) Unable to transfer b) Needs 2 people to transfer c) Requires 1 person to transfer d) Requires supervision for safety e) Independent in transferring	 0 3 8 12 15	
3. TOILET USE a) Fully dependent in toileting b) Requires help to get on and off toilet, handling clothes, wipe and flush c) Requires some help in pulling up, and down the pants d) Minimal supervision required for safety e) Use toilet independently	 0 3 5 8 10	
4. BLADDER CONTROL a) Incontinent or has indwelling catheter b) Frequent (more than once a day). Needs help to apply incontinence aids c) Generally dry during the day, but requires diapers at night d) Able to ask for toilet but has occasional incontinence (e.g. cannot wait for bed pan/ needs intermittent catherisation) e) Able to control bladder	 0 2 5 8 10	
5. BOWEL CONTROL a) Uncontrolled or faecal incontinence b) Very frequent (more than once a day) c) Frequent incontinence (more than once a week) d) Has occasional incontinent (once a week) e) Able to control bowels	 0 2 5 8 10	
SUB-TOTAL		

FUNCTIONAL ASSESSMENT INDEX	SCORE	REMARKS/ACTION
6. BATHING		
a) Total dependence in bathing	0	
b) Maximum help required in bathing	1	
c) Able to wash front but assistance is required with transfer, washing back and lower half etc.	3	
d) Able to bath but requires supervision for safety in toilet e.g. adjusting the water temperature	4	
e) Able to bath independently	5	
7. DRESSING		
a) Total dependence in all aspects of dressing	0	
b) Maximum help required in removing, putting on and fastening clothing	2	
c) Minimal assistance is required to fasten fasteners/remove and/ or put on pants	5	
d) Requires verbal prompting	8	
e) Independent dressing	10	
8. PERSONAL HYGIENE (WASHING & GROOMING)		
a) Unable to wash or change clothes when dirty (Totally dependent in all aspects)	0	
b) Maximum help required in al steps of personal hygiene	1	
c) Can wash and dress with some prompting and assistance	3	
d) Minimal assistance required (e.g. to prepare a basin of water, toiletries etc)	4	
e) Can wash face, comb hair, clean teeth and shave independently	5	
9. FEEDING		
a) Total dependence in all aspects and needs to feed (requires IV or tube feeding)	0	
b) Can manipulate with a spoon, but requires active assistance to direct spoon to mouth during meal	2	
c) Able to feed self but needs help to spread butter, cut meat and pour drink	5	
d) Needs some prompting and encouragement to eat	8	
e) Able to feed self independently	10	
SUB-TOTAL		

FUNCTIONAL ASSESSMENT INDEX	SCORE	REMARKS/ACTION
10. STAIR CLIMBING		
a) Unable	0	
b) Requires two people to support	2	
c) Requires one person to support	5	
d) Able to ascend/ descend with walking aids and supervision for safety	8	
e) Able to climb stairs independently with or without aids	10	
SUB-TOTAL		
GRAND TOTAL		

11. Assessment on Communication

(Please tick ☑ how the individual communicates)

- ❒ Communicates mainly by speech
- ❒ Communicates mainly by gestures, e.g. pointing
- ❒ Understands and responds to simple, familiar instructions
- ❒ Understands and responds to most instructions
- ❒ Does not respond to others' effort at communicating

Please indicate how the individual communicates in situation below:

- ❒ Requests attention by ______________________________
- ❒ Requests preferred item/activities by______________________________
- ❒ Requests help by______________________________
- ❒ Expresses tiredness by ______________________________
- ❒ Indicates physical pain by ______________________________
- ❒ Indicates confusion or unhappiness by______________________________
- ❒ Protests or rejects a situation or activity by ______________________________
- ❒ Shows you something or place by ______________________________
- ❒ Tells you something has happened by ______________________________

12. ASSESSMENT ON PROBLEM BEHAVIOURS (***OPTIONAL***)

To be filled in only if there is a history of behavioural problems. Please attach relevant psychological/psychiatric report if available.

	Description	**Remarks**
❒	Restlessness	
❒	Shouts or screams	
❒	Excessive Crying	
❒	Aggressiveness	
❒	Destructive behaviours	
❒	Disruptive behaviours	
❒	Self-injurious behaviours	
❒	Absconds	
❒	Wanders aimlessly	
❒	Withdrawn	
❒	Lethargic	
❒	Demands excessive attention	
❒	Ritualistic behaviours	
❒	Inappropriate sexual behaviours	
❒	Fixates on certain objects	
❒	Sensitive to sound	
❒	Sensitive to touch	
❒	Uncooperative and resistant	
❒	Phobia	
❒	Others	

16. Diet

❒ Soft ❒ Normal ❒ Blended ❒ Low Sodium ❒ Low Fat

❒ Vegetarian Remarks: ______________________________
❒ Halal Remarks: ______________________________
❒ No beef Remarks: ______________________________
❒ No mutton Remarks: ______________________________
❒ Diabetic diet Remarks: ______________________________
❒ Others Remarks: ______________________________

Please indicate the likes and dislikes of the individual.

	Likes	**Dislikes**
Food		
Drink		

17. Recreational Activities

Please tick (√) activity(s) that the individual enjoys

- ❒ Gross motor activities – walking / running / swinging
- ❒ Fine motor / table top activities - toys, games
- ❒ Reading and writing
- ❒ Arts and crafts
- ❒ Interacting with others
- ❒ Watching television
- ❒ Listening to music and dancing
- ❒ Helping out in doing household tasks
- ❒ Others (specify) _______________

18. Additional Information

- Psychologist, Occupational Therapist and Physiotherapist Assessment Reports
- Other reports (if necessary to support the referral)

Report Prepared By:

Name: ____________________________ Signature: ___________________________________

Designation: ______________________ Name of Agency: ______________________________

Contact Address: ____

Telephone: ___________________ Fax No. : _________________ Email: ___________________

For Official Use only

Case worker in-charge _______________________ Date of receipt _______________________

Date Approved _______________________ Date Confirmed ________________________

Annex A

Acknowledgement of Referral

Date:___________

To:

Case Worker: ____

Referring Agency: ____

FAX Number: ____

From:

Case Worker: ____

Day Activity Centre ____

FAX Number: ____

Thank you for your referral of __________________________________ (applicant's name) which dated __________________ for admission to our Day Activity Centre.

❐	We are currently reviewing the case and will give you a reply as soon as we can.
❐	We have reviewed the case and have made an appointment with the applicant and /or their caregiver(s) on ________________/______________(date / time)
	☐ Sheltered Workshop or ☐ at their home. or ☐ ___________ (Please tick (√) the appropriate venue)
	We will inform you of the outcome

❐	We have assessed and will be accepting the applicant. We have informed the family that he/she is scheduled to start on:____
❐	We are unable to accept the applicant because____
	____
	____