REFERRAL FORM

DATE (dd/mm/yyyy)						PLEASE AFFIX STICKY LABEL HERE
CENTRE	☐ ACC (HG)	☐ ACC (SM)	☐ ACC (FP)	☐ ACC (BB, PR, YS)	☐ IES	
TEL NO.	6386 9338	6812 0888	6202 9669	6562 4881	6812 9600	
FAX NO.	6385 8816	6812 0889	6202 9668	6562 4882	6812 9601	

WE WOULD LIKE TO REFER THE BELOW-MENTIONED PERSON FOR

☐ RESIDENTIAL SERVICE ☐ DAY REHAB SERVICE ☐ VOCATIONAL PLACEMENT ☐ COMMUNITY-BASED SUPPORT

REASON FOR REFERRAL

☐ VOCATIONAL REHABILITATION ☐ FAMILY ISSUE ☐ INADEQUATE ILLNESS/SYMPTOM/MEDICAL MANAGEMENT

☐ LACKED INDEPENDENT LIVING SKILLS ☐ COMMUNITY RE-INTEGRATION ☐ AWAITING ACCOMMODATION (Duration _____)

☐ LACKED SOCIAL SUPPORT ☐ SOCIAL INTERACTION ☐ OTHERS (Please specify)

PATIENT PARTICULARS

NAME (Underline surname)	NRIC / PASSPORT / OTHERS	
	GENDER ☐ MALE	☐ FEMALE
RELIGION	DATE OF BIRTH (dd/mm/yyyy)	AGE

RACE ☐ CHINESE ☐ INDIAN ☐ MALAY ☐ EURASIAN ☐ OTHERS (Please specify)

NATIONALITY ☐ SINGAPOREAN ☐ SINGAPORE PR ☐ OTHERS (Please specify)

MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ SEPARATED ☐ WIDOWED

ADDRESS	TELEPHONE (Home)	TELEPHONE (Office)	TELEPHONE (Mobile)

OUTPATIENT CLINIC/INPATIENT WARD	WARD/CLINIC TELEPHONE

MEDICAL/MENTAL HISTORY (This section to be completed by a psychiatrist)

DIAGNOSIS (Please attach additional report if necessary)	ONSET OF ILLNESS

BRIEF PSYCHIATRIC HISTORY, INCLUDING PRESENT PROBLEM (Please attach additional report if necessary)

SUICIDE IDEATIONS / ATTEMPTS WITHIN THE LAST 3 MONTHS	☐ YES	☐ NO	_____
SIGNIFICANT RISK BEHAVIOURS - SELF HARM	☐ YES	☐ NO	_____
SIGNIFICANT RISK BEHAVIOURS - SEXUAL OFFENCES	☐ YES	☐ NO	_____
SIGNIFICANT RISK BEHAVIOURS - EXTREME IMPULSIVITY	☐ YES	☐ NO	_____
HISTORY OF VIOLENT / AGGRESSIVE BEHAVIOUR (INCLUDING VERBAL) TOWARDS	☐ PERSON	☐ OBJECT	☐ BOTH ☐ NONE
PREVIOUS CRIMINAL RECORD	☐ YES	☐ NO	☐ DATE (dd/mm/yyyy) _____
ECT	☐ YES	☐ NO	☐ DATE (dd/mm/yyyy) _____

PSYCHO-SOCIAL ASSESSMENT

☐ RESTLESS ☐ DISINHIBITED ☐ AGGRESSIVE ☐ AVOLITIONAL ☐ OTHERS (Please specify)

DRUG ALLERGIES (If any)

MEDICATION (Oral and parenteral)

NAME	DOSAGE	FREQUENCY	NAME	DOSAGE	FREQUENCY
1			5		
2			6		
3			7		
4			8		

MEDICAL/MENTAL HISTORY (This section to be completed by a psychiatrist)	
BLOOD PRESSURE (BP)	CHEST X-RAY (CXR)
URINE SUGAR AND PROTEINS	OTHER PHYSICAL ILLNESS
DSM-IV-TR AXES	
AXIS I	
AXIS II	
AXIS III	
AXIS IV	
AXIS V (Global assessment of functioning scale)	
COMPLETED BY (Name of psychiatrist)	SIGNATURE
FROM (Hospital/Clinic/Department)	
SOCIAL HISTORY (This section to be completed by a social worker)	
GENOGRAM (Please attach additional report if necessary)	
SOCIAL REPORT (Please attach additional report if necessary)	

EMPLOYMENT HISTORY (Please attach additional reports if necessary)

IS MEMBER A RECIPIENT OF PSYCHOSOCIAL SERVICES IN THE PAST?

☐ YES If yes ☐ HCC ☐ SCC ☐ CRSS ☐ ESS ☐ OTHERS

☐ NO

HOUSEHOLD INCOME (Means testing)

MONTHLY PER CAPITA ($)	RESIDENTIAL (Singaporean)	RESIDENTIAL (Permanent Resident)
0 - 700	75% ☐	50% ☐
701 - 1,100	60% ☐	40% ☐
1,101 - 1,600	50% ☐	30% ☐
1,601 - 1,800	40% ☐	20% ☐
1,801 - 2,600	20% ☐	10% ☐
2,601 and above	0% ☐	0% ☐

MONTHLY PER CAPITA ($)	DAY CARE (Singaporean)	DAY CARE (Permanent Resident)
0 - 700	80% ☐	55% ☐
701 - 1,100	75% ☐	50% ☐
1,101 - 1,600	60% ☐	40% ☐
1,601 - 1,800	50% ☐	30% ☐
1,801 - 2,600	30% ☐	15% ☐
2,601 and above	0% ☐	0% ☐

Please submit 'Means-Test Declaration Form' and supporting documents for all categories.

CAREGIVER INFORMATION

NAME		RELATIONSHIP
ADDRESS		OCCUPATION
TELEPHONE (Home)	TELEPHONE (Office)	TELEPHONE (Mobile)

REFERRAL SOURCE

NAME AND DESIGNATION	FROM (Hospital/Clinic/Polyclinic)
CONTACT NO.	FAX NO.
EMAIL	