

REFERRAL FORM

DATE (dd/mm/yyyy)					PLEASE AFFIX STICKY LABEL HERE
CENTRE	<input type="checkbox"/> CRSS	<input type="checkbox"/> HCC	<input type="checkbox"/> SCC	<input type="checkbox"/> ESS	
TELEPHONE NO.	6562 4881	6386 9338	6781 8113	6567 1713	
FAX NO.	6562 4882	6385 8816	6781 0823	6567 1716	
WE WOULD LIKE TO REFER THE BELOW-MENTIONED PERSON FOR					
<input type="checkbox"/> RESIDENTIAL SERVICE <input type="checkbox"/> DAY REHAB SERVICE <input type="checkbox"/> VOCATIONAL PLACEMENT <input type="checkbox"/> CRSS					
REASON FOR REFERRAL					
<input type="checkbox"/> VOCATIONAL REHABILITATION <input type="checkbox"/> FAMILY ISSUE <input type="checkbox"/> INADEQUATE ILLNESS/SYMPATOM/MEDICAL MANAGEMENT <input type="checkbox"/> LACKED INDEPENDENT LIVING SKILLS <input type="checkbox"/> COMMUNITY RE-INTEGRATION <input type="checkbox"/> AWAITING ACCOMMODATION (Duration _____) <input type="checkbox"/> LACKED SOCIAL SUPPORT <input type="checkbox"/> SOCIAL INTERACTION <input type="checkbox"/> OTHERS (Please specify)					
PATIENT PARTICULARS					
NAME (Underline surname)			NRIC / PASSPORT / OTHERS		
			GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		
RELIGION			DATE OF BIRTH (dd/mm/yyyy)		AGE
RACE <input type="checkbox"/> CHINESE <input type="checkbox"/> INDIAN <input type="checkbox"/> MALAY <input type="checkbox"/> EURASIAN <input type="checkbox"/> UNKNOWN <input type="checkbox"/> DECLINED TO ANSWER <input type="checkbox"/> OTHERS (Please specify)					
MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> SEPARATED <input type="checkbox"/> 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 ATTEMPT WITHIN THE LAST 3 MONTHS <input type="checkbox"/> YES <input type="checkbox"/> NO _____ SIGNIFICANT RISK BEHAVIOURS - SELF HARM <input type="checkbox"/> YES <input type="checkbox"/> NO _____ SIGNIFICANT RISK BEHAVIOURS - SEXUAL OFFENCES <input type="checkbox"/> YES <input type="checkbox"/> NO _____ SIGNIFICANT RISK BEHAVIOURS - EXTREME IMPULSIVITY <input type="checkbox"/> YES <input type="checkbox"/> NO _____ HISTORY OF VIOLENT BEHAVIOUR TOWARDS <input type="checkbox"/> PERSON <input type="checkbox"/> OBJECT <input type="checkbox"/> BOTH <input type="checkbox"/> NONE PREVIOUS CRIMINAL RECORD <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> DATE (dd/mm/yyyy) _____ ECT <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> DATE (dd/mm/yyyy) _____					
PSYCHO-SOCIAL ASSESSMENT					
<input type="checkbox"/> RESTLESS <input type="checkbox"/> DISINHIBITED <input type="checkbox"/> AGGRESSIVE <input type="checkbox"/> AVOLITIONAL <input type="checkbox"/> 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 5 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 CRSS HCC SCC ESS OTHERS
 NO

FAMILY INCOME (Means testing)

MONTHLY PER CAPITA INCOME	RESIDENTIAL (Singapore Citizen)	RESIDENTIAL (Permanent Resident)
≤ \$360	75% <input type="checkbox"/>	65% <input type="checkbox"/>
\$361 - \$550	70% <input type="checkbox"/>	60% <input type="checkbox"/>
\$551 - \$750	60% <input type="checkbox"/>	50% <input type="checkbox"/>
\$751 - \$950	50% <input type="checkbox"/>	40% <input type="checkbox"/>
\$951 - \$1,150	40% <input type="checkbox"/>	30% <input type="checkbox"/>
\$1,151 - \$1,300	30% <input type="checkbox"/>	20% <input type="checkbox"/>
\$1,301 - \$1,350	20% <input type="checkbox"/>	10% <input type="checkbox"/>
\$1,351 - \$1,400	10% <input type="checkbox"/>	0% <input type="checkbox"/>
> \$1,401	0% <input type="checkbox"/>	0% <input type="checkbox"/>

MONTHLY PER CAPITA INCOME	DAY REHAB SERVICE (Singapore Citizen)	DAY REHAB SERVICE (Permanent Resident)
≤ \$360	75% <input type="checkbox"/>	65% <input type="checkbox"/>
\$361 - \$950	50% <input type="checkbox"/>	40% <input type="checkbox"/>
\$951 - \$1,400	25% <input type="checkbox"/>	15% <input type="checkbox"/>
> \$1,400	0% <input type="checkbox"/>	0% <input type="checkbox"/>

Please submit 'Application for Government Subsidy for Step-down Care' form and supporting documents for all categories.

NAME (Family member to be present at interview)	RELATIONSHIP
ADDRESS	OCCUPATION
TELEPHONE (Home)	TELEPHONE (Office)
	TELEPHONE (Mobile)

REFERRAL SOURCE

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