



REFERRAL FORM

Email to referral@clubheal.org.sg

SERVICES REQUIRED	
<input type="checkbox"/> COMIT Club HEAL @ Admiralty, Marsiling, Sembawang West, Woodgrove and Woodlands (Community Intervention Team)	<input type="checkbox"/> CREST Club HEAL @ Admiralty and Woodgrove (Community Resources, Engagement and Support Team)
<input type="checkbox"/> COMIT Club HEAL @ Nationwide (Community Intervention Team)	<input type="checkbox"/> CREST Club HEAL @ Pasir Ris Central, Pasir Ris East, Pasir Ris West, Tampines Central, Tampines Changkat, Tampines East, Tampines North and Tampines West (Community Resources, Engagement and Support Team)
<input type="checkbox"/> CREST Caregivers Club HEAL @ Nationwide (Community Resources, Engagement and Support Team - Caregivers)	<input type="checkbox"/> CREST Club HEAL @ Marsiling (Community Resources, Engagement and Support Team)
<input type="checkbox"/> CREST Club HEAL @ Geylang Serai and Mountbatten (Community Resources, Engagement and Support Team)	

SECTION 1: REFERRAL DETAILS		
Agency Name:		Date of Referral:
Name of Referring Staff:		Designation:
Tel No:	Fax No:	Email:

Has client / *family member consented to this referral and to the disclosure of enclosed information? Yes No

**(If client lacks mental capacity to give consent, client's immediate family member or caregiver can give consent on his/her behalf)*

**(If client is below 21 years, please obtain parental/guardian written consent)* Yes No

SECTION 2A: Services Required	SECTION 2B: Client Presenting Issues
<input type="checkbox"/> Psychiatric Day Rehabilitation <input type="checkbox"/> Counselling Service <input type="checkbox"/> Case Management <input type="checkbox"/> Illness / Symptom Management <input type="checkbox"/> Medication Compliance & Management <input type="checkbox"/> Caregiver Support / Psychoeducation	<input type="checkbox"/> Financial Issue <input type="checkbox"/> Employment Issue <input type="checkbox"/> Lodging/Housing Issue <input type="checkbox"/> Lack of Family Support <input type="checkbox"/> Social Isolation <input type="checkbox"/> Lack of Independent Living Skills <input type="checkbox"/> Others (Please Specify):
Reason for Referral to Club HEAL:	

SECTION 3: PERSONAL PARTICULARS OF CLIENT (All fields are required to be filled out)		
Name:		NRIC:
Citizenship: <input type="checkbox"/> Singaporean <input type="checkbox"/> Singapore PR <input type="checkbox"/> Others		Race: <input type="checkbox"/> Chinese <input type="checkbox"/> Malay <input type="checkbox"/> Indian <input type="checkbox"/> Others
Gender: Male / Female / Unspecified	Date of Birth:	Age:
Psychiatric Diagnosis: <input type="checkbox"/> Diagnosed with mental health condition (please indicate): <input type="checkbox"/> Suspected to have a mental health condition		Physical Conditions:
Currently on Medication: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Previously on medication, but stopped taking		
Within the last 3 months, has there been any incidence of the following: <input type="checkbox"/> Suicide Attempt <input type="checkbox"/> Self Harm <input type="checkbox"/> Violent Behaviour <input type="checkbox"/> Sexual Offence <input type="checkbox"/> Extreme Impulsivity		
Activities of Daily Living (Mobility, Transferring, Toileting, Showering, Feeding, Dressing): <input type="checkbox"/> Independent <input type="checkbox"/> Requires Some Assistance <input type="checkbox"/> Requires Full Assistance Additional Remarks:		Mobility: <input type="checkbox"/> Independent <input type="checkbox"/> Ambulant with Assistance <input type="checkbox"/> Wheelchair-Assisted <input type="checkbox"/> Bed-bound Additional Remarks:
NRIC Address:		Postal Code:
Current Residing Address: <input type="checkbox"/> As above (tick if address is as above)		Postal Code:
Contact No (Home):	Contact No (Mobile):	Contact No (Office):
Employment Status: <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Unemployed <input type="checkbox"/> Others (Remarks):		Occupation:

Period of Previous/Current* Employment: *please delete accordingly	Education Background:
Language Spoken: <input type="checkbox"/> English <input type="checkbox"/> Malay <input type="checkbox"/> Mandarin <input type="checkbox"/> Tamil <input type="checkbox"/> Others	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Others
Home Ownership: <input type="checkbox"/> Rental <input type="checkbox"/> Purchased <input type="checkbox"/> Lodging	Religion: <input type="checkbox"/> Buddhism <input type="checkbox"/> Christianity <input type="checkbox"/> Hinduism <input type="checkbox"/> Islam <input type="checkbox"/> Taoism <input type="checkbox"/> No Religion <input type="checkbox"/> Others (Remarks):
Living Arrangement: <input type="checkbox"/> Family <input type="checkbox"/> Spouse <input type="checkbox"/> Relatives <input type="checkbox"/> Friends <input type="checkbox"/> Alone <input type="checkbox"/> Domestic Helper <input type="checkbox"/> Co-Tenants <input type="checkbox"/> Others (Specify):	Type of Housing: <input type="checkbox"/> HDB 1room <input type="checkbox"/> HDB 2room <input type="checkbox"/> HDB 3room <input type="checkbox"/> HDB 4room <input type="checkbox"/> HDB 5room <input type="checkbox"/> HDB Executive <input type="checkbox"/> HDB Maisonette <input type="checkbox"/> HDB Elderly Studio Apartment <input type="checkbox"/> Condominium/Private Apartment <input type="checkbox"/> Landed Property <input type="checkbox"/> Others (Specify):

SECTION 4: PARTICULARS OF NEXT-OF-KIN / MAIN CAREGIVER (All fields are required to be filled out)

Name (Next-of-Kin):		Relationship to Client:
Contact Nm (Home):	Contact Nm (Mobile):	Contact Nm (Office):
Residing with Referred Client? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Employment Status: <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Unemployed <input type="checkbox"/> Others (Remarks):	Marital Status:	Date of Birth / Age:
Name (Main Caregiver): <input type="checkbox"/> As above (tick if next-of-kin stated above is main caregiver)		Relationship to Client:
Residing with Referred Client? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Contact No (Home):	Contact No (Mobile):	Contact No (Office):
Employment Status: <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Unemployed <input type="checkbox"/> Others (Remarks):	Marital Status:	Date of Birth / Age:

SECTION 5: CURRENT SERVICES / FORMAL SUPPORT NETWORK

Hospitals: _____
 Polyclinic: _____
 GP / Private Medical Practitioner: _____
 Social Service Office (SSO): _____
 Family Service Centre (FSC): _____
 Dementia Day Care Centre / Active Aging Centres*: _____
 Home Based Services (eg Home Medical / Home Nursing / Home Therapy / Home Help / Home Care) *: _____
 Other Social Services (Please Indicate): _____
 *please delete accordingly

SECTION 6: DOCUMENTS ATTACHED (Kindly tick if attached)

Client's NRIC Family Member's NRIC Social Report Medical Discharge Summary List of Medications
 Physiotherapy/Occupational Therapy Summary (if available)
 Other Documents: _____

SECTION 7: OTHER RELEVANT INFORMATION
