Psychiatric Rehabilitation Service

Hope . Empowerment . Acceptance . Love

REFERRAL FORM

Email to **referral@clubheal.org.sg**

SERVICES REQUIRED	
☐ **COMIT** (COMmunity Intervention Team)	☐ **CREST** (Community Resources and Support Engagement Team) (serving Marsiling, Woodgrove, Admiralty, Woodlands & Sembawang Divisions)

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.)

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

SECTION 3: PERSONAL PARTICULARS OF CLIENT		
Name:		**NRIC:**
Citizenship: ☐ Singaporean ☐ Singapore PR ☐ Others		**Race:** ☐ Chinese ☐ Malay ☐ Indian ☐Others
Gender: Male / Female / Unspecified	**Date of Birth:**	**Age:**
Psychiatric Diagnosis: ☐ Diagnosed with mental health condition (please indicate): ☐ Suspected to have a mental health condition		**Physical Conditions:**
Currently on Medication: ☐ Yes ☐ No ☐ Previously on medication, but stopped taking		
Within the last 3 months, has there been any incidence of the following: ☐ Suicide Attempt ☐ Self Harm ☐ Violent Behaviour ☐ Sexual Offence ☐ Extreme Impulsivity		
Activities of Daily Living (Mobility, Transferring, Toileting, Showering, Feeding, Dressing): ☐ Independent ☐ Requires Some Assistance ☐ Requires Full Assistance Additional Remarks:	**Mobility:** ☐ Independent ☐ Ambulant with Assistance ☐ Wheelchair-Assisted ☐ Bed-bound Additional Remarks:	
NRIC Address:		**Postal Code:**
Current Residing Address: ☐ As above (tick if address is as above)		**Postal Code:**
Contact No (Home):	**Contact No (Mobile):**	**Contact No (Office):**
Employment Status: ☐ Full-Time ☐ Part-Time ☐ Unemployed ☐ Others (Remarks):		**Occupation:**
Period of Previous/Current* Employment: *please delete accordingly	**Education Background:**	
Language Spoken: ☐ English ☐ Malay ☐ Mandarin ☐ Tamil ☐ Others	**Marital Status:** ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐ Others	
Home Ownership: ☐ Rental ☐ Purchased ☐ Lodging	**Religion:** ☐ Buddhism ☐ Christianity ☐ Hinduism ☐ Islam ☐ Taoism ☐ No Religion ☐ Others (Remarks):	
Living Arrangement: ☐ Family ☐ Spouse ☐ Relatives ☐ Friends ☐ Alone ☐ Domestic Helper ☐ Co-Tenants ☐ Others (Specify):	**Type of Housing**: ☐ HDB 1room ☐ HDB 2room ☐ HDB 3room ☐ HDB 4room ☐ HDB 5room ☐ HDB Executive ☐ HDB Maisonette ☐ HDB Elderly Studio Apartment ☐ Condominium/Private Apartment ☐ Landed Property ☐ Others (Specify):	

SECTION 4: PARTICULARS OF NEXT-OF-KIN / MAIN CAREGIVER		
Name (Next-of-Kin):		**Relationship to Client:**
Contact Nm (Home):	**Contact Nm (Mobile):**	**Contact Nm (Office):**
Residing with Referred Client? ☐ Yes ☐ No		
Employment Status: ☐ Full-Time ☐ Part-Time ☐ Unemployed ☐ Others (Remarks):	**Marital Status:**	**Date of Birth / Age:**
Name (Main Caregiver): ☐ As above (tick if next-of-kin stated above is main caregiver)		**Relationship to Client:**
Residing with Referred Client? ☐ Yes ☐ No		
Contact No (Home):	**Contact No (Mobile):**	**Contact No (Office):**
Employment Status: ☐ Full-Time ☐ Part-Time ☐ Unemployed ☐ Others (Remarks):	**Marital Status:**	**Date of Birth / Age:**

SECTION 5: CURRENT SERVICES / FORMAL SUPPORT NETWORK

☐ Hospital : _____
☐ Polyclinic : _____
☐ GP / Private Medical Practitioner: _____
☐ Social Service Office (SSO): _____
☐ Family Service Centre (FSC): _____
☐ Dementia Day Care Centre / Social Day Care Centre* : _____
☐ 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

For Club HEAL's offical use only (For Authorising Officer's action)	
Application Status: ☐ Approved ☐ Rejected	**$10.00 Entrance Fee** ☐ Paid Receipt No: ☐ Waived

Case will be Referred to:
☐ Case Manager (COMIT)
☐ Counsellor (COMIT)
☐ Mental Health Nurse (COMIT)
☐ Social Worker (COMIT)
☐ Social Worker / Social Work Associate (CREST)
☐ Programme Executive (for Psychiatric Day Rehab service only) Indicate Centre: ☐ Bukit Batok East ☐ Marsiling ☐ Pasir Ris

Preliminary Action to be taken:_____

Authorising Officer:

NAME	SIGNATURE	DATE
_____	_____	_____