



Headquarters
2 Peng Nguan Street
SPD Ability Centre
S(168955)

SPD@Jurong
Blk 337 Jurong East Ave 1
#01-1562
S(600337)

SPD@Tampines
Blk 866 Tampines St 83
#01-237
S(520866)

SPD@Toa Payoh
Blk 249 Kim Keat Link
#01-83
S(310249)

REFERRAL FORM

Please ensure ALL applicable sections of the form are completed.

SPD Hotline: 65790 700 Fax: 6236 6378

Email: information@spd.org.sg

SPD Website: www.spd.org.sg

Please tick the services needed:

CHILDREN SERVICES

- Continuing Therapy Programme (below 16 years old)
 - Occupational Therapy
 - Speech Therapy
- School Integration Support (6 years old and above)
 - Early Intervention Programme for Infants and Children (0 to 6 year old) – *Apply through SG Enable*
 - Development Support Programme (3 to 6 years old) – *Apply through respective preschools*

ADULT AND ELDERLY SERVICES

Rehabilitation:

- Therapy Services* (17 years old and above)
 - Centre-based
 - Home-based
 - Physiotherapy
 - Occupational Therapy
 - Speech Therapy

**Apply through Agency for Integrated Care if subsidy is required*

- Day Activity Centre (16 years old – 55 years old)
 - Day Care Centre (55 years old and above) – *Apply through Agency for Integrated Care*

Training & Employment:

- Vocational Training (IT related)
- Transition Programme for Employment
- Sheltered Workshop (16 years old and above)
- Employment Support (16 years old and above)

SPECIALISED SERVICES

- Assistive Technology
- Social Support
 - Counselling
 - Caregiver Support
 - Social & Financial Assistance



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**SPD PRIVACY POLICY
 SELF-DECLARATION FOR CLIENTS**

I fully understand and agree that the personal information which I have provided, including my health, medical, social, financial information and photographs, may be disclosed to other agencies or individuals for the purposes as stated below. I trust that the information will strictly be used for the purpose stated:

- a) For processing my application, including assessments and evaluations, for services, programmes and assistance offered by other organisations, in order to provide holistic support in my best interest;
- b) For professional discussions between SPD and other agencies involved in the provision of my care, for the purpose of enhancing service delivery in my best interest;
- c) For generating social, welfare, financial, regulatory, management or other related reports and performance of analytics. Personal data will be anonymised where possible or applicable;
- d) To relevant government authorities, ministries, statutory boards, agencies or any person to whom disclosure is allowed or required by law, regulation or any other applicable instrument, for legal purposes;
- e) For public education, advocacy, outreach, fund raising, and/or other related activities;
- f) Any other purposes related to providing me with the necessary and relevant assistance for my situation.

I agree for SPD to contact me for any other purpose related to the services SPD is providing or had provided me with and/or matters which I have an on-going relationship with SPD.

If applicable:

This information has been translated to me in _____ (language) by
 _____ (staff's name, designation/organisation)
 on _____ (date).

 Name of client*/caregiver/parent

 Signature/Thumbprint &
 Date

**For minors below 21 years old, or clients above 21 years old and certified mentally incapacitated, consent will be obtained from parent and/or legal guardian on client's behalf.*



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Client's Particulars

Name: _____ Gender: Male Female

NRIC/Birth Cert: _____ [IC type: Pink Blue]

Date of birth: _____ (dd/mm/yyyy) Nationality: _____

Race: Chinese Malay Indian Eurasian Others: _____

Language spoken: English Mandarin Malay Tamil Dialect/Others: _____

Address: _____ Singapore (_____)

Contact No: _____ (Home) _____ (Hp) _____ (Office)

Email Address: _____

Disability Type: Physical Sensory (Visual / Hearing*) Intellectual Developmental

Usage of Mobility/Visual/Hearing Device: No Yes (Pls specify: _____)

Able to travel by Public Transport independently: No Yes (Bus / MRT / Taxi*)

**Please delete accordingly*

Key Family Contact

Name: _____ Relationship to client: _____

Main Contact No.: _____ Language spoken: _____

Email Address: _____

Referral Source

Name: _____ Designation: _____

Organisation: _____ Contact No.: _____

Email Address: _____ Fax No.: _____

Date of Referral: _____

For Official Use

Referral received by: _____
(Name of Staff, Department/Division) Signature & Date



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MEDICAL SUMMARY REPORT

This section should only be filled up by Singapore Registered Medical Practitioner

Name: _____ NRIC/Birth Cert No.: _____

Nature of Disability

- | | | |
|---|---|---|
| <input type="checkbox"/> Physical Disability | <input type="checkbox"/> Multiple Disabilities | <input type="checkbox"/> Visual impairment |
| <input type="checkbox"/> Intellectual Disability | <input type="checkbox"/> Psychiatric Disability | <input type="checkbox"/> Hearing impairment |
| <input type="checkbox"/> Developmental Disability | <input type="checkbox"/> Others: _____ | |

Medical History / Diagnosis / Description of difficulties:

Information Required	Please tick <input checked="" type="checkbox"/> YES or NO		Please specify details (if applicable)
Speech and hearing impairment	<input type="checkbox"/>	<input type="checkbox"/>	
Visual Impairment	<input type="checkbox"/>	<input type="checkbox"/>	
Infectious disease (e.g. TB, Hepatitis B, HIV, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	
History of Heart Disease (If applicable, please state the precautionary measures)	<input type="checkbox"/>	<input type="checkbox"/>	Blood Pressure: _____
History of Lungs Disease (If applicable, please state the precautionary measures)	<input type="checkbox"/>	<input type="checkbox"/>	
Has history of reactive airway disease/ asthma	<input type="checkbox"/>	<input type="checkbox"/>	
Problems with bladder and bowel Function	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetic Conditions	<input type="checkbox"/>	<input type="checkbox"/>	
History of epileptic episodes, paralysis, seizure or other abnormality of the central nervous system.	<input type="checkbox"/>	<input type="checkbox"/>	If yes, pls state: - frequency: _____ - last episode: _____
History of mental illness e.g. depression / schizophrenia / bipolar disorders etc (If applicable)	<input type="checkbox"/>	<input type="checkbox"/>	
History of aggressive and violent behaviour	<input type="checkbox"/>	<input type="checkbox"/>	
Has swallowing dysfunction: on tube feeding/ gastrostomy	<input type="checkbox"/>	<input type="checkbox"/>	



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Requires special diet or allergy to food		<input type="checkbox"/>	<input type="checkbox"/>	
Current Medication: Drug Allergy? <input type="checkbox"/> No <input type="checkbox"/> Yes (please state: _____)				
1		4		
2		5		
3		6		
Medical Follow Up: <input type="checkbox"/> No <input type="checkbox"/> Yes				
	Hospital/ Clinic	Name of Doctor	Date & Time	
1				
2				
3				
Therapy History (Please attach Physiotherapy / Occupational Therapy / Speech Therapy report(s) if available).				
Other comments/observations/additional reason for referral:				

RECOMMENDATION	
_____ (Name of Client) is <input type="checkbox"/> fit / <input type="checkbox"/> unfit for participation in Therapy Services / Day Care / Vocational Training Programmes <i>(please delete accordingly)</i> .	
_____ Name & Signature of Examining Medical Practitioner	_____ Date
Name & Address of Clinic: _____ _____	



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ANNEX A: FINANCIAL ASSESSMENT

This form should be completed if applying for financial assistance.

Name: _____ NRIC/Birth Cert No.: _____

1. FINANCIAL INFORMATION (Self and Immediate family members)						
Name	Age	Relationship	Staying Together Y/N	Marital Status	Occupation	Gross Salary
TOTAL GROSS FAMILY INCOME:						
PCI:						

2. HOUSING INFORMATION

HDB Flat

Purchased Rental
 1 – room 2 – room 3 – room 4 – room 5 – room
 Executive Maisonette Jumbo Executive Condominium

Private

Purchased Rental
 Private Condominium / Cluster Homes Landed Housing



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ANNEX B: EDUCATION & EMPLOYMENT BACKGROUND

This form should be completed if applying for training and employment services.

Name: _____ NRIC/Birth Cert No.: _____

1. Education Information

Current School / Level: _____

Highest Education Level: No Formal Education Primary Secondary

N' levels Passed O' levels Passed

A' levels Passed

ITE Certificate: _____

Diploma: _____

Degree: _____

Postgraduate: _____

Others: _____

2. Employment Information

Working Status: Currently working: _____
(Current job)

Currently unemployed: _____
(Last employment / Date)

Never been employed