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



# REFERRAL FORM (Adults & Elderly)

Please ensure applicable sections of the form are completed.
SPD Hotline: 65790 700
Email: information@spd.org.sg
SPD Website: www.spd.org.sg

We recommend you encrypt the completed Referral Form and with the password, send in separate emails to us.

| **Please tick the services needed:** | **Annex Required** |
|---|---|
| **ADULT SERVICES:** | |
| **Rehabilitation:** | |
| ❒ Day Activity Centre, HQ (18 years old – 55 years old) | |
| ❒ Therapy Services, HQ & Toa Payoh (18 years old and above) | |
| ❒ Day Care Centre, Toa Payoh (18 years old and above) | |
| **Employment/ Vocational Training Programme:** | |
| ❒ Transition to Employment, HQ (18 years old – 60 years old) | **A** |
| ❒ Sheltered Workshop, HQ (18 years old and above) | **A** |
| ❒ Employment Support, Enabling Village (16 years old and above) | **A** |
| **SPECIALISED SERVICES:** | |
| ❒ Assistive Technology, Enabling Village | |
| ❒ Social Support under Specialised Case Management Program | |

**For Official Use**

Referral received by:

_____ (Name of Staff, Department/Division)

_____ Signature & Date

## CONSENT AND DECLARATION

I acknowledge that I have read SPD's Privacy Policy (https://www.spd.org.sg/useful-links/privacy-policy/) and consent to SPD collecting, using and disclosing the personal data provided in the Referral Form and all its completed Parts for the following purposes in accordance with the Personal Data Protection Act 2012 and SPD's Privacy Policy:

a) Assessing my application, for the services, programmes and/or assistance offered and/or administered by SPD;

b) Providing me with the services, programmes and/or assistance for which I am admitted or granted if my application is successful;

c) Facilitating training for SPD's professional team; and

a) For submission to relevant ministries and statutory boards, to satisfy regulatory requirements.

***Please tick applicable:***

❒ I further agree to SPD disclosing the personal data for professional referral to other agencies for assessing my eligibility for their services.

❒ If my application to SPD be unsuccessful, I agree for the personal data to be disclosed for the further purpose of professional referral by SPD to other agencies for their services.

Where I have not agreed to disclosure by ticking any of the above, I have been notified and/or am aware that SPD may not be in a position to continue providing me with the services I am seeking.

I declare that all information in the Referral Form and its Parts (and attached documents, if any) are true to the best of my knowledge and belief, and I have not wilfully suppressed any material facts. I agree that the services, programmes and/or assistance to which I am admitted or granted may be withdrawn/terminated without any notice if any information is found to be untrue or material facts have been wilfully suppressed.

In addition, I further give my consent to the collection, use and disclosure of my personal data for:

❒ Contacting me regarding use and disclosure for SPD's annual reports, newsletters and sharing of human interest stories

❒ For training, workshops and outreach

❒ For research by SPD or in collaboration with its partners (As far as possible, data used will be anonymised)

❒ None of the above

and acknowledge that if I do not consent to any of the above, I may still receive services, programmes and assistance.

***Opt-In:***

Please tick the relevant boxes below:

❒ I would like to receive information about SPD including but not limited to its updates, services and programmes via the following channels:

- ❒ Email
- ❒ Text message
- ❒ Telephone call

❒ I do not wish to receive any information about 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 (_____)

Housing: ❒ Purchased ❒ Rental ❒ Lodge

Accommodation: ❒ Private ❒ HDB Flat

❒ Private Condominium / Cluster Homes
❒ Landed Housing

❒ 1 – room ❒ 2 – room ❒ 3 – room
❒ 4 – room ❒ 5 – room ❒ Executive
❒ Maisonette ❒ Jumbo
❒ Executive Condominium

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

Email Address: _____

Usage of Mobility/Visual/Hearing Device/AAC: ❒ 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: _____ Date of Referral: _____

## MEDICAL SUMMARY REPORT

This section should only be filled up by Healthcare Professionals (SMC-registered Medical Practitioner, AHPC Full-registered OT/PT/ST or SNB-registered Advanced Practice Nurse)

**Client's Name: _____ NRIC/Birth Cert No.: _____**

**Recent Hospital Discharge Summary/ Healthcare Professional Report (s).** [Please tick the checkbox(s)]

☐ Hospital Discharge Summary ☐ Healthcare Professional Report

☐ Psychological Report ☐ Physiotherapy

☐ Occupational Therapy ☐ Speech Therapy

[Please attached the supporting document(s)]

**Nature of Disability**: [Please tick the checkbox(s)]

☐ Physical Disability ☐ Visual Disability ☐ Hearing Disability

☐ Intellectual Disability ☐ Psychiatric Disability ☐ Developmental Disability

☐ Others: _____

**Medical History / Diagnosis / Description of difficulties:**

**Screening:** (Please tick the checkbox)

| | | | |
|---|---|---|---|
| **Infectious disease** (e.g. TB, Hepatitis B, HIV, etc.) | ❒ No | ❒ Yes | If yes, please state: _____ |
| | Precaution: | ❒ Standard | ❒ Others: _____ |
| | | ❒Contact | |
| **Other Precautions to be taken or conditions that would require closer monitoring:** (e.g. Heart Disease, Lung Diseases, Asthma, Diabetic, Depression, Schizophrenia) | ❒ No | ❒ Yes | If yes, please state: _____ |
| **History of epileptic/ seizure episodes** | ❒ No | ❒ Yes | If yes, please state:<br>- Frequency: _____<br>- Last episode: _____<br>- Triggers: _____ |
| **History of aggressive and violent behaviour** | ❒ No | ❒ Yes | If yes, please state:<br>- Frequency: _____<br>- Last episode: _____<br>- Triggers: _____ |

**Requires special diet or allergy to food** ❒ No ❒ Yes If yes, please state: _____

**Current Functional Status:** (Please tick the checkbox)

**Speech Impairment:** ❒ No ❒ Yes If yes, please state: _____

**Visual Disability:** ❒ No ❒ Yes If yes, please state: _____

**Hearing Disability:** ❒ No ❒ Yes If yes, please state: _____

**Mental Status:** ❒ Rational ❒ Confused ❒ Unable to respond
❒ Others: _____

**Mobility Status:** ❒ Bedbound ❒ Wheelchair ❒ Ambulating (Proceed to Walking Aid)
❒ *Manual Wheelchair*
❒ *Motorised Wheelchair*
❒ *Motorised Scooter*

***Walking Aid:*** ❒ N/A ❒ Walking Stick / Umbrella
❒ Quad Stick ❒ Walking Frame
❒ Others: _____

**Assistance level required for wheelchair/ ambulating**

❒ Independent ❒ Minimal Assistance ❒ Moderate Assistance ❒ Max Assistance/ Dependent

**Activity Tolerance** ❒ Poor ( 0 to < 15 min) ❒ Fair (15 to 45 min) ❒ Good (>45 min)

**Transfers:** ❒ Independent ❒ Minimal Assistance ❒ Moderate Assistance ❒ Max Assistance/ Dependent

**Feeding:** ❒ Independent ❒ Need Assistance
❒ Dependent: ❒ *Oral*
❒ *NG tube*
❒ *PEG*

**Toileting:** ❒ Independent ❒ Need Assistance
❒ Dependent/ Incontinent: (select one from below)
❒ *on diapers*
❒ *urinary catheter*

**Bowel Management:** ❒ Continent ❒ Diapers ❒ Colostomy ❒ ileostomy
❒ Others: _____

**Respiratory Care:** ❒ N/A ❒ Oxygen Therapy ❒ Suction ❒ BIPAP

| | | | |
|---|---|---|---|
| | ❒Tracheostomy Care ❒ Others: _____ | | |
| **Medication Management:** | ❒ Independent ❒ Need Assistance | | |
| **Current Medication:** Drug Allergy? ❒ No ❒ Yes (please state:_____) | | | |
| 1 | | 4 | |
| 2 | | 5 | |
| 3 | | 6 | |
| **Medical Follow Up:** ❒ No ❒ Yes | | | |

| | **Hospital/ Clinic** | **Name of Doctor** | **Date & Time** |
|---|---|---|---|
| 1 | | | |
| 2 | | | |
| 3 | | | |

**RECOMMENDATION**

*For Therapy Services/ Day Care Centre/ Day Activity Centre/ Transition to Employment:*

| | | |
|---|---|---|
| A1. Does client require rehabilitation? | ❒ No | ❒ Yes (please proceed to A2) |
| A2. Is client fit to undergo rehabilitation services? | ❒ No | ❒ Yes |

*For Transition to Employment/ Sheltered Workshop/ Employment Support:*

| | | |
|---|---|---|
| B1. Is client fit for vocational training? | ❒ No | ❒ Yes |
| B2. Is client fit for work? | ❒ No | ❒ Yes |

Reason for referral: _____

_____

_____ _____

Name, MCR/AHPC/SNB No & Signature of Examining Healthcare Professional) Date

Name & Address of institution/ Hospital: _____

_____

## ANNEX A: EDUCATION & EMPLOYMENT BACKGROUND

This section should be completed only if applying for employment services.

**Client's Name:** _____ **NRIC No.:** _____

### 1. Education Information

- *Please bring along official educational documents during intake assessment such as certificates, transcripts, testimonials*

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

- *Please bring along official employment documents during intake assessment such as resume, employment letter, certificates, testimonials, latest payslip*

❒ Currently working : _____ (Current job)

❒ Currently unemployed : _____ (Last employment / Date)

❒ Never been employed

❒ How motivated are you to return to work? :_____ (on a scale 0-10)

### 3. Proof of Disability (Compulsory Document)

- *Please attach document(s)*

❒ Doctor Memo

❒ Public Transport Concession issued by SGEnable

❒ Membership with other disability associations

i.e. HWA, SADeaf, SAVH, or NCSS Special needs card

❒ NA

### 4. Fit for Work Certification

- *Please attach document*

❒ Certified fit for work : _____ (Date of doctor's certification)

❒ Certified permanent unfit for work : _____ (Date of doctor's certification)