



## 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 I agree that the services, programmes and/or assistance to which I am admitted or granted may be withdrawn/terminated without any notice if any information is found to be untrue or material facts have been wilfully suppressed.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.*

**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

- |  |  |                                   |                                    |
|--|--|-----------------------------------|------------------------------------|
| <input type="checkbox"/> Private Condominium / Cluster Homes | <input type="checkbox"/> 1 – room              | <input type="checkbox"/> 2 – room | <input type="checkbox"/> 3 – room  |
| <input type="checkbox"/> Landed Housing                      | <input type="checkbox"/> 4 – room              | <input type="checkbox"/> 5 – room | <input type="checkbox"/> Executive |
|  | <input type="checkbox"/> Maisonette            | <input type="checkbox"/> Jumbo    |                                    |
|  | <input type="checkbox"/> 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.:** \_\_\_\_\_

<b>Recent Hospital Discharge Summary/ Healthcare Professional Report (s).</b> [Please tick the checkbox(s)]			
<input type="checkbox"/> Hospital Discharge Summary	<input type="checkbox"/> Healthcare Professional Report		
	<input type="checkbox"/> Psychological Report	<input type="checkbox"/> Physiotherapy	
	<input type="checkbox"/> Occupational Therapy	<input type="checkbox"/> Speech Therapy	
[Please attached the supporting document(s)]			
<b>Nature of Disability:</b> [Please tick the checkbox(s)]			
<input type="checkbox"/> Physical Disability	<input type="checkbox"/> Visual Disability	<input type="checkbox"/> Hearing Disability	
<input type="checkbox"/> Intellectual Disability	<input type="checkbox"/> Psychiatric Disability	<input type="checkbox"/> Developmental Disability	
<input type="checkbox"/> Others: _____			
<b>Medical History / Diagnosis / Description of difficulties:</b>			
<b>Screening:</b> (Please tick the checkbox)			
<b>Infectious disease</b> (e.g. TB, Hepatitis B, HIV, etc.)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes, please state: _____
	Precaution:		<input type="checkbox"/> Standard <input type="checkbox"/> Others: _____
			<input type="checkbox"/> Contact
<b>Other Precautions to be taken or conditions that would require closer monitoring:</b> (e.g. Heart Disease, Lung Diseases, Asthma, Diabetic, Depression, Schizophrenia)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes, please state: _____
<b>History of epileptic/ seizure episodes</b>	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes, please state:
	- Frequency: _____		
	- Last episode: _____		
	- Triggers: _____		
<b>History of aggressive and violent behaviour</b>	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes, please state:
	- Frequency: _____		
	- Last episode: _____		
	- Triggers: _____		

<b>Requires special diet or allergy to food</b>	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes, please state: _____
<b>Current Functional Status: (Please tick the checkbox)</b>			
<b>Speech Impairment:</b>	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes, please state: _____
<b>Visual Disability:</b>	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes, please state: _____
<b>Hearing Disability:</b>	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes, please state: _____
<b>Mental Status:</b>	<input type="checkbox"/> Rational	<input type="checkbox"/> Confused	<input type="checkbox"/> Unable to respond
	<input type="checkbox"/> Others: _____		
<b>Mobility Status:</b>	<input type="checkbox"/> Bedbound	<input type="checkbox"/> Wheelchair	<input type="checkbox"/> Ambulating (Proceed to Walking Aid)
		<input type="checkbox"/> <i>Manual Wheelchair</i>	
		<input type="checkbox"/> <i>Motorised Wheelchair</i>	
		<input type="checkbox"/> <i>Motorised Scooter</i>	
<b>Walking Aid:</b>	<input type="checkbox"/> N/A	<input type="checkbox"/> Walking Stick / Umbrella	
	<input type="checkbox"/> Quad Stick	<input type="checkbox"/> Walking Frame	
	<input type="checkbox"/> Others: _____		
<b>Assistance level required for wheelchair/ ambulating</b>			
	<input type="checkbox"/> Independent	<input type="checkbox"/> Minimal Assistance	<input type="checkbox"/> Moderate Assistance
			<input type="checkbox"/> Max Assistance/ Dependent
<b>Activity Tolerance</b>	<input type="checkbox"/> Poor ( 0 to < 15 min)	<input type="checkbox"/> Fair (15 to 45 min)	<input type="checkbox"/> Good (>45 min)
<b>Transfers:</b>	<input type="checkbox"/> Independent	<input type="checkbox"/> Minimal Assistance	<input type="checkbox"/> Moderate Assistance
			<input type="checkbox"/> Max Assistance/ Dependent
<b>Feeding:</b>	<input type="checkbox"/> Independent	<input type="checkbox"/> Need Assistance	
	<input type="checkbox"/> Dependent:	<input type="checkbox"/> <i>Oral</i>	
		<input type="checkbox"/> <i>NG tube</i>	
		<input type="checkbox"/> <i>PEG</i>	
<b>Toileting:</b>	<input type="checkbox"/> Independent	<input type="checkbox"/> Need Assistance	
	<input type="checkbox"/> Dependent/ Incontinent: (select one from below)		
	<input type="checkbox"/> <i>on diapers</i>		
	<input type="checkbox"/> <i>urinary catheter</i>		
<b>Bowel Management:</b>	<input type="checkbox"/> Continent	<input type="checkbox"/> Diapers	<input type="checkbox"/> Colostomy
	<input type="checkbox"/> Others: _____		<input type="checkbox"/> ileostomy
<b>Respiratory Care:</b>	<input type="checkbox"/> N/A	<input type="checkbox"/> Oxygen Therapy	<input type="checkbox"/> Suction
			<input type="checkbox"/> BIPAP

<input type="checkbox"/> Tracheostomy Care		<input type="checkbox"/> Others: _____			
<b>Medication Management:</b>		<input type="checkbox"/> Independent		<input type="checkbox"/> Need Assistance	
<b>Current Medication:</b>					
Drug Allergy?		<input type="checkbox"/> No		<input type="checkbox"/> Yes (please state: _____)	
1		4			
2		5			
3		6			
<b>Medical Follow Up:</b>					
		<input type="checkbox"/> No		<input type="checkbox"/> Yes	
	<b>Hospital/ Clinic</b>	<b>Name of Doctor</b>		<b>Date &amp; Time</b>	
1					
2					
3					

**RECOMMENDATION**

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

A1. Does client require rehabilitation?	<input type="checkbox"/> No	<input type="checkbox"/> Yes (please proceed to A2)
A2. Is client fit to undergo rehabilitation services?	<input type="checkbox"/> No	<input type="checkbox"/> Yes

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

B1. Is client fit for vocational training?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
B2. Is client fit for work?	<input type="checkbox"/> No	<input type="checkbox"/> Yes

Reason for referral: \_\_\_\_\_

\_\_\_\_\_

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