Ren Ci Senior Care Centre Referral Form

Client / family has consented to this application and the disclosure of enclosed information to relevant service provider to facilitate application □ **Yes** □ **No**

REFERRAL TYPE

Day Rehabilitation □ Active Rehabilitation □ Maintenance Rehabilitation

Day Care □ Integrated Home and Day Care (IHDC) □ Maintenance Day Care
□ Dementia Day Care

Transport Required: □ Yes □ No **Escort Required:** □ Yes □ No
(Door-to-door service)

CLIENT INFORMATION

Name: _____ **Date of Birth:** _____
(dd/mm/yyyy)

NRIC/FIN No: _____ Age: _____

Residential Address: _____

_____

Contact Number: _____

Language Spoken: □English □Mandarin □Malay
□Tamil □Others: _____

CONTACT PERSON AND CARE GIVER INFORMATION

Main Spokesperson: _____

Relationship to client: _____

Contact Number: _____

Main Caregiver: _____
(Please specify)

MEDICAL HISTORY

Primary Diagnosis:
(*attach report if any)

MEDICAL HISTORY

Past Medical/Surgical History:

(*attach report if any)

Is client diagnosed with dementia? □ Yes □ No

(Please note: Clients referred for Dementia Day Care service **must be diagnosed** to be suffering from dementia by a SMC registered Medical Practitioner.)

Cognitive & Behavioural Symptoms: _____

(If any, please specify)

Medications/Dosage/Frequency:

(*attach report if any)

REHAB CERTIFICATION

Is client suitable and can benefit from rehabilitation? □ Yes □ No

(Please note: Only a SMC-registered Medical Practitioner or AHPC FULL-registered PT/OT/ST or SNB-registered Advanced Practice Nurse can certify the above.)

SCREENING

Does client current have any active infectious disease?

□ No □ Yes (specify): _____

Precaution: □Standard □Contact □Others: _____

CURRENT FUNCTIONAL STATUS

Mental Status: □Rational □Confused □Others: _____

Mobility Status: □ Ambulating □ Wheelchair □ Bedbound

Walking Aid: □ N/A □ Walking Stick □ Quad Stick
□ Walking Frame □Others: _____

Assistance Level: □ Independent □ Supervision □ Contact Guard
□ Minimal □ Moderate □ Maximum/Dependent

PARTICULARS OF MEDICAL HEALTHCARE PROFESSIONAL

Name & Signature: _____ Date: _____

Institution/Hospital: _____ Contact Number: _____