

Referral to Community Response Team

SECTION 1: REFERRING DETAILS	
<p>Reason for referral (you may tick more than one):</p> <p>Clients aged 50 and above:</p> <input type="checkbox"/> With dementia and having challenging behavioral issues. <input type="checkbox"/> With no dementia diagnosis but presented with symptoms of confusion, forgetfulness or behavioral changes. <input type="checkbox"/> With symptoms of mood disorders (not on long term specialist follow up). <input type="checkbox"/> Lack of prompt access to medical care (home bound/ refuse to go clinic or hospital/ unable to obtain an early appointment with current health care provider). <input type="checkbox"/> Caregiver unable to cope with the care.	
<p>Date of Referral: / / (DD/MM/YY)</p>	
<p>Referring Agency (pls specify):</p>	
<p>Referring Person:</p>	<p>Designation:</p>
<p>Tel No: (O)</p>	<p>(Hp)</p>
<p>Email:</p>	
<p>Has client/family member consented to this referral and to the disclosure of enclosed information to St Luke's Hospital?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
SECTION 2: CLIENT'S PERSONAL DETAILS	
<p>Name:</p>	<p>NRIC:</p>
<p>Date of birth: / / (DD/MM/YY)</p>	<p>Age:</p>
<p>Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female</p>	
<p>NRIC Address:</p> <p style="text-align: right;">Postal Code ()</p>	
<p>Residential Address: <input type="checkbox"/> Please tick if same as above</p> <p style="text-align: right;">Postal Code ()</p>	
<p>Nationality: <input type="checkbox"/> Singapore Citizen <input type="checkbox"/> Permanent Resident <input type="checkbox"/> Non-citizen (pls specify):</p>	
<p>Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced</p> <p><input type="checkbox"/> Widowed</p>	
<p>Race: <input type="checkbox"/> Chinese <input type="checkbox"/> Indian <input type="checkbox"/> Malay <input type="checkbox"/> Others:</p>	
<p>Religion (pls specify):</p>	
<p>Occupational Status:</p> <p><input type="checkbox"/> Employed (pls specify): _____</p> <p><input type="checkbox"/> Unemployed (pls specify previous occupation): _____</p> <p><input type="checkbox"/> Retired (pls specify previous occupation): _____</p>	
<p>Spoken Language(s) / Dialect(s):</p>	
<p>Housing Details:</p> <p><input type="checkbox"/> HDB (pls specify): _____ <input type="checkbox"/> Maisonette <input type="checkbox"/> Condo <input type="checkbox"/> Landed Property <input type="checkbox"/> Studio Apartment</p> <p><input type="checkbox"/> Others: _____</p> <hr style="border-top: 1px dashed black;"/> <p><input type="checkbox"/> Owned <input type="checkbox"/> Rental <input type="checkbox"/> Lodged</p>	

Genogram:

Blank area for drawing a genogram.

SECTION 3: PARTICULARS OF FAMILY MAIN CAREGIVER

Name:		Age:
Gender:	<input type="checkbox"/> Male	<input type="checkbox"/> Female
Relationship:		
<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Family (e.g. siblings, parent) <input type="checkbox"/> Relative (e.g. aunt, uncle, niece, nephew)
<input type="checkbox"/> Others:		
Number of years of caregiving:		
<input type="checkbox"/> less than 1 year <input type="checkbox"/> 1-2 years <input type="checkbox"/> 2-5 years <input type="checkbox"/> 5-8 years <input type="checkbox"/> 9-10 years <input type="checkbox"/> above ten years		
Employment Status:		
<input type="checkbox"/> Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired		
Is patient also being look after by maid? :		
<input type="checkbox"/> Yes <input type="checkbox"/> No		
Is main caregiver also the main decision maker?		
<input type="checkbox"/> Yes <input type="checkbox"/> No		
If no, please state name of main decision maker: _____		
Contact number of main decision maker: _____		
Contact number of the main family caregiver: _____		

SECTION 4: Client's Medical Information

Drug Allergy:	<input type="checkbox"/> Yes (pls specify):	<input type="checkbox"/> No
Current medical condition (e.g. diabetes, hypertension, stroke):		
<p>Blank area for describing current medical conditions.</p>		
Mobility Status:		
<input type="checkbox"/> Independent <input type="checkbox"/> Ambulant with assistance <input type="checkbox"/> Wheelchair assisted <input type="checkbox"/> Bedbound		
Assistive Devices:		

- | | | | |
|-------------------------------------|--|-------------------------------------|--|
| <input type="checkbox"/> N/A | <input type="checkbox"/> Walking stick | <input type="checkbox"/> Quad stick | <input type="checkbox"/> Walking Frame |
| <input type="checkbox"/> Wheelchair | <input type="checkbox"/> Geri-chair | <input type="checkbox"/> Commode | <input type="checkbox"/> Others (pls specify): |

Please list any existing medical appointments (Date/time/hospital or clinic/discipline):

Please list any current community services:

Please provide the following if any:

- Medical discharge summary
- Medication list
- Social Report / Information

For Official Use Only

Date Received:

Referral Status:

- Accepted
 Rejected
 Withdrawn

Reason for rejection / withdrawn: _____

Assessed by: _____ Date: _____

Referral code assigned: _____

Contact details:
 St Luke's Hospital
 2 Bukit Batok Street 11
 Singapore 659674
 Tel: 6895 3283
 Email: grp-crt@stluke.org.sg

Operating Hours:
 Mon to Fri: 8.30am – 5.30pm
 Closed on weekends and public holidays