

## St Luke's Hospital Community Intervention Team (SLH COMIT) - Patient Referral Form

SECTION 1: CONFIRMATION OF CONSENT		
I confirm that the client and/or main caregiver/NOK has consented to this referral and to the sharing of their personal data and patient's latest hospital discharge summary/medical memo to COMIT SLH for the purpose of this referral.		
Name of Referring Person: .		Date: .
SECTION 2: PATIENT'S DETAILS		
Name (as per NRIC): .		NRIC No.: .
Date of Birth: .	Age: .	Gender: .
NRIC Address: . Postal Code: ( . )		
Residential Address: <input type="checkbox"/> Please tick if same as above . Postal Code: ( . )		
Nationality: .	Race: .	Religion: .
Marital Status: .	Occupational Status: .	
Spoken Language(s) / Dialect(s): <input type="checkbox"/> English <input type="checkbox"/> Malay <input type="checkbox"/> Mandarin <input type="checkbox"/> Tamil <input type="checkbox"/> Cantonese <input type="checkbox"/> Hokkien <input type="checkbox"/> Teochew <input type="checkbox"/> Uncommunicative <input type="checkbox"/> Others (pls specify): .		
Housing Details: <input type="checkbox"/> HDB (pls specify type) . <input type="checkbox"/> Condo <input type="checkbox"/> Landed Property . <input type="checkbox"/> Others (pls specify): .		
Housing Ownership: <input type="checkbox"/> Lodging <input type="checkbox"/> Rent - HDB <input type="checkbox"/> Rent - Private <input type="checkbox"/> Owned		
Living Arrangements: (please tick all which apply) <input type="checkbox"/> Alone <input type="checkbox"/> Spouse <input type="checkbox"/> Child/Children <input type="checkbox"/> Foreign Domestic Worker <input type="checkbox"/> Grandchild/children <input type="checkbox"/> Others (pls specify): .		
SECTION 3: REFERRAL DETAILS		
Date of referral: .		
Reason(s) for referral: (Please tick all which apply)		
Client has or requires:		
<input type="checkbox"/> Dementia with BPSD	<input type="checkbox"/> Mild Cognitive Impairment (MCI)	
<input type="checkbox"/> Dementia without BPSD	<input type="checkbox"/> Suspected dementia	
<input type="checkbox"/> Caregiver support & education	<input type="checkbox"/> OT assessment & intervention	
<input type="checkbox"/> Low mood	<input type="checkbox"/> Mild to Moderate Depressive disorders	
<input type="checkbox"/> Mild to Moderate Anxiety disorders	<input type="checkbox"/> Stable Psychotic disorders (e.g. schizophrenia, delusional disorder)	
<input type="checkbox"/> Adjustment disorder	<input type="checkbox"/> Acute stress disorder	

SECTION 3: REFERRAL DETAILS	
<b>Description / Examples of Presenting Issues:</b> .	
SECTION 4: OTHER RELEVANT INFORMATION	
Kindly attach/provide the necessary information (tick all that is relevant) <input type="checkbox"/> Current Medical Report / Doctor's Memo <input type="checkbox"/> Current Medication List <input type="checkbox"/> Social Report	
<b>Family Background and Financial Information:</b> (Please attach Social Report / Genogram if available) .	
<b>Medical Information of Patient:</b>	
<b>Drug Allergy:</b> <input type="checkbox"/> No known drug allergy <input type="checkbox"/> Yes (pls specify): .	
<b>Primary Type of Comorbidities (e.g. diabetes, hypertension, hyperlipidemia):</b> .	
<b>Description of Mental Health / Dementia condition:</b> .	
<b>Current Mental Status:</b> (please tick all which apply) <input type="checkbox"/> Alert <input type="checkbox"/> Rational <input type="checkbox"/> Forgetful <input type="checkbox"/> Confused <input type="checkbox"/> Not able to follow command <input type="checkbox"/> Others (pls specify): .	
<b>Mobility Status:</b> (please tick all which apply) <input type="checkbox"/> Bedbound (Patient is not able to transfer from bed to chair) <input type="checkbox"/> Chair-bound (Patient is not able to walk or operate a wheelchair) <input type="checkbox"/> Home-bound (Patient is not able to visit neighbourhood places) <input type="checkbox"/> Neighbourhood-bound (Patient is not able to commute beyond the immediate neighbourhood) <input type="checkbox"/> Full mobility (Patient is able to visit public places in all parts of Singapore)	
<b>Level of Assistance</b> (pls specify, e.g. supervision, min assistance (1 man), max assistance (2 man)): .	
<b>Assistive Devices:</b> <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): .	

SECTION 4: OTHER RELEVANT INFORMATION
<b>Please list any follow up patient has for existing medical condition (clinic, doctor/Healthcare Professional):</b> <i>(e.g. NUH Cardiology, Dr Zee YX)</i> .
<b>Please list current community services known to and/or have been referred:</b> (e.g. daycare, home care) .

SECTION 5: MAIN CAREGIVER'S / NEXT-OF-KIN'S DETAILS			
<b>Name (as per NRIC):</b> .			
<table border="1" style="width: 100%;"> <tr> <td style="width: 33%;"><b>Gender:</b> .</td> <td style="width: 33%;"><b>Age:</b> .</td> <td style="width: 33%;"><b>Occupational Status:</b> .</td> </tr> </table>	<b>Gender:</b> .	<b>Age:</b> .	<b>Occupational Status:</b> .
<b>Gender:</b> .	<b>Age:</b> .	<b>Occupational Status:</b> .	
<b>Tel No:</b> (Home) . (Hp) . (Others) .			
<b>Spoken Language(s) / Dialect(s):</b> <input type="checkbox"/> English <input type="checkbox"/> Mandarin <input type="checkbox"/> Malay <input type="checkbox"/> Tamil <input type="checkbox"/> Cantonese <input type="checkbox"/> Hokkien <input type="checkbox"/> Teochew <input type="checkbox"/> Uncommunicative <input type="checkbox"/> Others <i>(pls specify)</i> : .			
<b>Relationship to Patient:</b> .			
<b>Number of years/months of caregiving:</b> .			
<b>Is main caregiver also the main spokesperson?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please state name of main spokesperson: . Contact details of main spokesperson: .			

SOURCE OF REFERRAL		
<b>Referring Agency</b> <i>(For self-referral, put "NA"):</i> (e.g. St Luke's Hospital)		
<table border="1" style="width: 100%;"> <tr> <td style="width: 60%;"><b>Referring Person:</b> .</td> <td style="width: 40%;"><b>Designation:</b> .</td> </tr> </table>	<b>Referring Person:</b> .	<b>Designation:</b> .
<b>Referring Person:</b> .	<b>Designation:</b> .	
<b>Tel No:</b> (Office) . (Hp) . (Others) .		
<b>E-mail address:</b> .		

FOR OFFICIAL USE ONLY
Date Received: .
Referral status: <input type="checkbox"/> Accepted / <input type="checkbox"/> Rejected / <input type="checkbox"/> Withdrawn
Reason for case rejection / withdrawn: .
Assessed by: .
Date: .
Case S/No. assigned: .

**Please send the completed Referral Form via e-mail to [slh-comit@stluke.org.sg](mailto:slh-comit@stluke.org.sg).**  
 Kindly call **6895 2794** for any enquiries, on Mondays to Fridays, 9 AM to 5.30 PM (except Public Holidays).