

Date				Drug allergies (if any)			
Centre		<input type="checkbox"/> HCC	<input type="checkbox"/> SCC	<input type="checkbox"/> CRSS		PLEASE AFFIX STICKY LABEL HERE	
Telephone No.		6386 9338	6781 8113	6562 4881			
Fax No.		6385 8816	6781 0823	6562 4882			

We would like to refer the below-mentioned person for							
<input type="checkbox"/> RESIDENTIAL CARE		<input type="checkbox"/> DAY CARE		<input type="checkbox"/> VOCATIONAL PLACEMENT		<input type="checkbox"/> CRSS	
Reason for Referral				Inadequate illness / symptom / medical management			
<input type="checkbox"/> Family issue		<input type="checkbox"/> Community Re-integration		<input type="checkbox"/> Lacked Independent Living Skills			
<input type="checkbox"/> Social Interaction		<input type="checkbox"/> Vocational rehabilitation		<input type="checkbox"/> Lacked Social Support		<input type="checkbox"/> Others _____	

PATIENT PARTICULARS									
Name (Underline Surname)				NRIC No.					
				Gender		<input type="checkbox"/> Male		<input type="checkbox"/> Female	
Religion				DOB (dd-mm-yyyy)			Age		
Race		<input type="checkbox"/> Chinese		<input type="checkbox"/> Indian		<input type="checkbox"/> Malay		<input type="checkbox"/> Declined to answer	
		<input type="checkbox"/> Eurasian		<input type="checkbox"/> Unknown		<input type="checkbox"/> Others, please specify:			
Marital Status		<input type="checkbox"/> Married		<input type="checkbox"/> Single		<input type="checkbox"/> Divorced		<input type="checkbox"/> Separated	<input type="checkbox"/> Widowed
Address				Home Phone		Office Phone	Mobile Phone		
OUTPATIENT CLINIC / INPATIENT WARD						Ward / Clinic Tel			

MEDICAL / MENTAL HISTORY (this section to be completed by a psychiatrist)											
Diagnosis				Onset of illness							
Brief psychiatric history, including present admission											
Suicide attempt within the last 3 months		<input type="checkbox"/> Yes		<input type="checkbox"/> No							
History of Violent Behaviour Towards		<input type="checkbox"/> Person		<input type="checkbox"/> Object		<input type="checkbox"/> Both <input type="checkbox"/> None					
Previous Criminal Record		<input type="checkbox"/> Yes		<input type="checkbox"/> No		Date _____					
ECT		<input type="checkbox"/> Yes		<input type="checkbox"/> No		Date _____					
Psycho-social Assessment		<input type="checkbox"/> Restless		<input type="checkbox"/> Disinhibited		<input type="checkbox"/> Aggressive		<input type="checkbox"/> Avolitional			
		<input type="checkbox"/> Others (please specify):									
MEDICATION (ORAL AND PARENTERAL)											
Name		Dosage		Frequency		Name		Dosage		Frequency	
1. _____		_____		_____		5. _____		_____		_____	
2. _____		_____		_____		6. _____		_____		_____	
3. _____		_____		_____		7. _____		_____		_____	
4. _____		_____		_____		8. _____		_____		_____	

Blood Pressure (BP)	Chest X-ray (CXR)
Urine Sugar & Proteins	Other physical illness
Completed by (name of psychiatrist)	Signature
From (hospital / clinic / department)	
SOCIAL HISTORY (this section to be completed by a social worker)	
Genogram	
Social Report (please attach additional report if necessary)	
Employment History	

Family Income (Means Tested)			
Monthly per capita Income:	\$ 0 - \$ 300	(75%)	<input type="checkbox"/>
	\$ 301 - \$ 700	(50%)	<input type="checkbox"/>
	\$ 701 - \$1000	(25%)	<input type="checkbox"/>
	Above \$1000	(0%)	<input type="checkbox"/>
Please submit Application for Government Subsidy for Step-down Care form & supporting documents.			

Family member to be present at interview		
Name		Relationship
Address		Occupation
Tel (Home)	(Office)	(Mobile)

REFERRAL SOURCE		
Medical Social Worker	From (hospital / clinic / polyclinic)	
Contact No.	Fax No.	E-mail