

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		<input type="checkbox"/> Awaiting Accommodation		<input type="checkbox"/> 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 <input type="checkbox"/> Restless <input type="checkbox"/> Disinhibited <input type="checkbox"/> Aggressive <input type="checkbox"/> Avolitional	
Assessment <input type="checkbox"/> Others (please specify):	

MEDICATION (ORAL AND PARENTERAL)					
Name		Dosage	Frequency	Name	
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