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## REFERRAL FORM

**Please note** - Pages 2 & 3: To be filled up by client/family member/Social Worker  
 - Pages 1, 4 & 5: To be filled up by Singapore Registered Medical Practitioner

Please tick service(s) required <sup>1</sup>:

<b>Children and Youth Services</b>	
<input type="checkbox"/> Therapy Outreach Programme for Pre-Schoolers (TOPPS) (age 3 - 6 years)	<input type="checkbox"/> Continuing Therapy (below 16 years) Please specify <input checked="" type="checkbox"/> : <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Speech Therapy
	<input type="checkbox"/> Integration support for physically disabled students in mainstream schools (age 6 years and above)
<b>Rehabilitation</b>	
<input type="checkbox"/> Adult and Geriatric Rehabilitation Centre (centre-based)	<input type="checkbox"/> Therapy@Home (home-based)
<b>Day Care*</b>	
<input type="checkbox"/> Day Activity Centre (age 16 - 55 years)	
<b>Vocational Skills and Training*</b>	
<input type="checkbox"/> Sheltered Workshop	<input type="checkbox"/> IT Training
<input type="checkbox"/> Apprenticeship (IT-related)	<input type="checkbox"/> Job Placement
<b>Technology*</b>	
<input type="checkbox"/> Assistive Technology	
<b>Case Management and Social Support</b>	
<input type="checkbox"/> Social Support/Counselling	<input type="checkbox"/> Caregiver Support

\* Services available at SPD Headquarters only

<sup>1</sup> The description and admission criteria of the various services and programmes are available on our website [www.spd.org.sg](http://www.spd.org.sg).

CLIENT'S PARTICULARS			
<b>Name:</b>		<b>NRIC/Birth Cert No.:</b> _____	
		<input type="checkbox"/> Pink IC <input type="checkbox"/> Blue IC	
<b>Nationality:</b>	<b>Gender:</b>	<input type="checkbox"/> Male <input type="checkbox"/> Female	<b>Date of Birth:</b> <b>Age:</b>
<b>Address:</b>			
<b>Telephone No:</b>			
(Home)	(HP)	(Office)	
<b>E-mail Address:</b>	<b>Marital Status:</b>	<b>Religion:</b>	
<b>Race:</b>	<b>Spoken Language:</b>		
<input type="checkbox"/> Chinese <input type="checkbox"/> Malay <input type="checkbox"/> Indian <input type="checkbox"/> Others: _____	<input type="checkbox"/> English <input type="checkbox"/> Mandarin <input type="checkbox"/> Teochew <input type="checkbox"/> Malay <input type="checkbox"/> Cantonese <input type="checkbox"/> Others: <input type="checkbox"/> Tamil <input type="checkbox"/> Hokkien		
<b>Highest Educational Level:</b>		<b>Current School/Level:</b>	
<input type="checkbox"/> No Formal Education <input type="checkbox"/> Primary <input type="checkbox"/> Secondary <input type="checkbox"/> GCE 'O' Levels <input type="checkbox"/> GCE 'N' Levels <input type="checkbox"/> GCE 'A' Levels <input type="checkbox"/> ITE Certificate in: _____ <input type="checkbox"/> Diploma in: _____ <input type="checkbox"/> Degree in: _____ <input type="checkbox"/> Postgraduate in: _____ <input type="checkbox"/> Others: _____			
		<b>Current/Last Employment (date):</b>	
		<b>Housing Type:</b>	
		<input type="checkbox"/> Nil <input type="checkbox"/> HDB Flat: _____ room <input type="checkbox"/> rental <input type="checkbox"/> purchased <input type="checkbox"/> Private Property - please state type: _____ <input type="checkbox"/> Others: _____	
		Lift landing: <input type="checkbox"/> Yes <input type="checkbox"/> No	
USAGE OF MOBILITY AIDS			
<input type="checkbox"/> No <input type="checkbox"/> Yes - <i>If yes, please indicate the mobility aid used:</i>			
<input type="checkbox"/> Wheelchair : <input type="checkbox"/> Manual <input type="checkbox"/> Motorised		<input type="checkbox"/> Walking Frame <input type="checkbox"/> Rollator	
<input type="checkbox"/> Walking Stick <input type="checkbox"/> Quadstick		<input type="checkbox"/> Others: _____	

ABILITY TO TRAVEL INDEPENDENTLY BY PUBLIC TRANSPORT						
<input type="checkbox"/> Able (please specify mode): _____ <input type="checkbox"/> Maybe able, but applicant has not been trained to travel on his/her own <input type="checkbox"/> Unable						
*FAMILY INFORMATION (Immediate family members)						
Name	Age	Relationship	Staying Together Yes/No	Marital Status	Occupation	Gross Salary
<b>In case of emergency, to contact:</b> Name: _____ Relationship: _____ Contact No: _____						

\*To apply for subsidies, please submit the latest pay slips/CPF statements of immediate family members staying together with client

CLIENT/CLIENT'S MAIN REPRESENTATIVE/ REFFERAL AGENCY	
Name: _____	Signature: _____
Organisation: _____	Designation: _____
Tel: _____ Fax: _____	E-mail: _____
Date: _____	

**ADDITIONAL INFORMATION** - Please enclose the following relevant reports:

- Social Report and/or Occupational Therapist, Physiotherapist, Speech Therapist, Psychologist report(s)

### MEDICAL SUMMARY REPORT

(This section onwards should only be filled by a Singapore Registered Medical Practitioner)

Name: \_\_\_\_\_ NRIC/Birth Cert No.: \_\_\_\_\_

Medical History/Diagnosis/Description of difficulties:		
Information Required	Please tick <input checked="" type="checkbox"/> YES or <input type="checkbox"/> NO	Please specify details, if available/applicable
Speech and hearing impairment	<input type="checkbox"/> <input type="checkbox"/>	
Visual Impairment	<input type="checkbox"/> <input type="checkbox"/>	
Infectious disease (e.g. TB, Hepatitis B, HIV, etc.)	<input type="checkbox"/> <input type="checkbox"/>	
History of Heart Disease (If applicable, please state the precautionary measures)	<input type="checkbox"/> <input type="checkbox"/>	Blood Pressure: _____
History of Lungs Disease (If applicable, please state the precautionary measures)	<input type="checkbox"/> <input type="checkbox"/>	
Has history of reactive airway disease/asthma	<input type="checkbox"/> <input type="checkbox"/>	
Problems with bladder and bowel function	<input type="checkbox"/> <input type="checkbox"/>	
Diabetic conditions	<input type="checkbox"/> <input type="checkbox"/>	
History of epileptic episodes, paralysis, seizure or other abnormality of the central nervous system.	<input type="checkbox"/> <input type="checkbox"/>	If yes, pls state: - frequency: _____ - last episode: _____
History of mental illness e.g. depression/schizophrenia/bipolar disorders etc (if applicable)	<input type="checkbox"/> <input type="checkbox"/>	
History of aggressive and violent behaviour	<input type="checkbox"/> <input type="checkbox"/>	
Has swallowing dysfunction: on tube feeding/ gastrostomy	<input type="checkbox"/> <input type="checkbox"/>	
Requires special diet or allergy to food	<input type="checkbox"/> <input type="checkbox"/>	

<b>Current Medication:</b> Drug Allergy? <input type="checkbox"/> No <input type="checkbox"/> Yes (please state: _____)			
1		4	
2		5	
3		6	
<b>Medical Follow Up:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes			
	<b>Hospital/Clinic</b>	<b>Name of Doctor</b>	<b>Date &amp; Time</b>
1			
2			
3			
Therapy History (Please attach Physiotherapy/Occupational Therapy/Speech Therapy report(s) if available).			
Other comments/observations:			

ADDITIONAL REASON(S) FOR REFERRAL							
<input type="checkbox"/>	Emotional Support	<input type="checkbox"/>	Crisis Support	<input type="checkbox"/>	Grief and Loss	<input type="checkbox"/>	Critical Illness
<input type="checkbox"/>	Marital/Family Problem	<input type="checkbox"/>	Enhance Well-being	<input type="checkbox"/>	Motivational Counselling	<input type="checkbox"/>	Life Skills Development
Others, please provide brief description of problem & additional information:							
NATURE OF DISABILITY							
<input type="checkbox"/>	Physical disability	<input type="checkbox"/>	Multiple disabilities	<input type="checkbox"/>	Visual impairment		
<input type="checkbox"/>	Intellectual disability	<input type="checkbox"/>	Psychiatric disability	<input type="checkbox"/>	Hearing impairment		
<input type="checkbox"/>	Developmental disability	<input type="checkbox"/>	Others: _____				

\_\_\_\_\_ (Name of Client) is  fit /  unfit  
for participation in Therapy Services/Day Activity Centre/Vocational Training Programmes  
(please delete accordingly).

\_\_\_\_\_  
Signature and Name of Examining Medical Practitioner

\_\_\_\_\_  
Date

Name and Address of Clinic : \_\_\_\_\_

Contact No. : \_\_\_\_\_