

## DYSPHAGIA MANAGEMENT PROGRAMME

### REFERRAL FORM

*(This section may be filled up by medical social worker, referral agency or client/ family caregiver)*

At Society for the Physically Disabled, we are pleased to offer a Dysphagia Management Programme\*(i.e. Swallowing Management Programme) that aims to help disabled clients (including elderly) with swallowing difficulties to help regain or improve their swallowing function.

PARTICULARS		
<b>Name:</b>  	<b>NRIC / FIN No:</b> _____  IC Colour: <input type="checkbox"/> S'pore / Pink <input type="checkbox"/> S'pore Resident/ Blue <input type="checkbox"/> Not available <input type="checkbox"/> Others: _____	
<b>Nationality:</b>	<b>Gender:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female	<b>Date of Birth/Age:</b>
<b>Address:</b>		
<b>Telephone No:</b> (H)	(HP)	(O)
<b>E-mail Address:</b>	<b>Marital Status:</b>	<b>Religion:</b>
<b>Race:</b> <input type="checkbox"/> Chinese <input type="checkbox"/> Malay <input type="checkbox"/> Indian <input type="checkbox"/> Others: _____	<b>Spoken Language:</b> <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>Educational Level:</b> <input type="checkbox"/> No Formal Education <input type="checkbox"/> Primary <input type="checkbox"/> Secondary <input type="checkbox"/> O Levels <input type="checkbox"/> N Levels <input type="checkbox"/> A Levels <input type="checkbox"/> ITE Certificate in: _____ <input type="checkbox"/> Diploma in: _____ <input type="checkbox"/> Degree in: _____ <input type="checkbox"/> Postgraduate in: _____	<b>Current / Last Employment (date):</b>  <b>Housing Type:</b> <input type="checkbox"/> Nil <input type="checkbox"/> HDB Flat: _____ room rental / purchased <input type="checkbox"/> Private Property - please state type: _____  <input type="checkbox"/> Others: _____	
USAGE OF MOBILITY AIDS		
<input type="checkbox"/> <b>No</b> <input type="checkbox"/> <b>Yes - If yes, please indicate the mobility aid use: (*Delete where appropriate)</b>		
<input type="checkbox"/> Wheelchair : Manual / Motorized* <input type="checkbox"/> Walking Frame <input type="checkbox"/> Rollator		
<input type="checkbox"/> Walking Stick / Quad stick* <input type="checkbox"/> Others: _____		

FAMILY INFORMATION						
Name	Age	Relationship	Staying Together Y/N	Marital Status	Occupation	Gross Salary (applicable only if applying for subsidy)
<b>In case of emergency, to contact:</b>						
Name: _____ Relationship: _____						
Contact No: _____ (H) _____ (HP) _____ (O)						
APPLICANT/ CARE GIVER/ REFERRING AGENCY* <i>(delete where applicable)</i>						
Name: _____ Signature: _____						
Designation/ Relationship: _____ Organisation: _____						
Tel: _____ Fax: _____ E-mail: _____						

**ADDITIONAL INFORMATION –**

*Please enclose the following relevant reports:*

- Social report (if available)
- (a) pay slips, income tax assessment or any other document proof of income of applicant and family members staying together (b) declaration form for those family members who are not able to provide salary slip (c) public assistance card (if subsidy is required)

**KINDLY FAX ALL REFERRALS TO: 6236 6378**

**Enquiries: 6579 0760**

**Email: [information@spd.org.sg](mailto:information@spd.org.sg) Website: [www.spd.org.sg](http://www.spd.org.sg)**

## DYSPHAGIA MANAGEMENT PROGRAMME

### MEDICAL REFERRAL AND SUMMARY REPORT

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

At Society for the Physically Disabled, we are pleased to offer a Dysphagia Management Programme (i.e. Swallowing Management Programme) that aims to help disabled clients (including elderly) with swallowing difficulties to help regain or improve their swallowing function.

PARTICULARS		
<b>Name:</b>		<b>NRIC No:</b> IC Colour: <input type="checkbox"/> S'pore / Pink <input type="checkbox"/> S'pore Resident/ Blue <input type="checkbox"/> Not available <input type="checkbox"/> Others: _____
<b>Nationality:</b>	<b>Gender:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female	<b>Date of Birth/Age:</b>
<b>Address:</b>		
<b>Telephone No:</b> (H)	(HP)	(O)
NATURE OF DISABILITY		
<input type="checkbox"/> Physical Disability <input type="checkbox"/> Intellectual Disability <input type="checkbox"/> Developmental Disability	<input type="checkbox"/> Multiple Disabilities <input type="checkbox"/> Psychiatric Disability <input type="checkbox"/> Others: _____	<input type="checkbox"/> Visual impairment: Partial / Total* <input type="checkbox"/> Hearing impairment: Partial/ Total* <i>(*Delete where appropriate)</i>
<b>Diagnosis/ Medical History:</b> _____ _____ _____ _____		
Information Required	Please tick <input checked="" type="checkbox"/> YES or 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 Lung 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"/>	
Has problems with bladder and bowel function	<input type="checkbox"/> <input type="checkbox"/>	

Has 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 (pls state: _____)			
1		3	
2		4	
<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			
<b>Therapy History</b> (Please attach Physiotherapy / Occupational Therapy / Speech Therapy reports if available). _____ _____ _____			
Other comments/observations: _____ _____			

I wish to certify that the \_\_\_\_\_ (Name of client) is fit for participation in SPD's Dysphagia Management Programme. I also confirm that,

- The patient is medically fit to tolerate electrical stimulation.
- It is safe to offer oral trials with food and drink (applies to patients with tube feeding/ gastrostomy).

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

\_\_\_\_\_  
Date of Examination

Name and address of Clinic : \_\_\_\_\_  
\_\_\_\_\_

Contact No/ Email: \_\_\_\_\_