

SPD HQ: 2 Peng Nguan Street, SPD Ability Centre, Singapore 168955
 SPD@Tampines: Blk 866 Tampines St 83 #01-237, Singapore 520866
 Enquiries: 65790764 / 65790749 Email: information@spd.org.sg Website: www.spd.org.sg
Kindly fax all referrals to: 6236 6378

REFERRAL FORM

At Society for the Physically Disabled, we offer a range of services that cater to people with disabilities. Please tick services needed¹:

Children and Youth Services	
<input type="checkbox"/> Therapy Outreach to Pre-schoolers (TOPPS)	<input type="checkbox"/> Continuing Therapy (age 0-16 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)
Rehabilitation	
<input type="checkbox"/> Adult and Geriatric Rehabilitation Centre (centre- based)	<input type="checkbox"/> Therapy @ Home (home-based)
Day Care*	
<input type="checkbox"/> Day Activity Centre (age 16-55 years)	
Vocational Skills and Training*	
<input type="checkbox"/> Sheltered Workshop (manufacturing)	<input type="checkbox"/> IT Training
<input type="checkbox"/> Apprenticeship (IT related)	<input type="checkbox"/> Job Placement
Technology*	
<input type="checkbox"/> Assistive Technology	
Case Management and Social Support	
<input type="checkbox"/> Social Support / Counselling	<input type="checkbox"/> Caregiver Support

* Services available at SPD HQ only

¹ The description and admission criteria of the various services and programmes are available on our website www.spd.org.sg.

CLIENT'S PARTICULARS			
Name:		NRIC No/ Birth Cert: <input type="checkbox"/> Pink IC <input type="checkbox"/> Blue IC	
Nationality:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth/Age:	
Address:			
Telephone No: (H)		(HP)	(O)
E-mail Address:		Marital Status:	Religion:
Race: <input type="checkbox"/> Chinese <input type="checkbox"/> Malay <input type="checkbox"/> Indian <input type="checkbox"/> Others: _____		Spoken Language: <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	
Highest Educational Level: <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: _____ <input type="checkbox"/> Others: _____		Current School / Level:	
		Current / Last Employment (date):	
		Housing Type: <input type="checkbox"/> Nil <input type="checkbox"/> HDB Flat: _____ room rental / purchased <input type="checkbox"/> Private Property - please state type: _____ <input type="checkbox"/> Others: _____ Lift landing: <input type="checkbox"/> Yes <input type="checkbox"/> No	
♣ 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
<input type="checkbox"/> Others, please provide brief description of problem & additional information:			
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* (*Delete where appropriate)	
Diagnosis/ Description of difficulties (eg. poor handwriting): _____ _____			

MEDICAL SUMMARY REPORT

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

Name: _____ NRIC No / Birth Cert: _____

Diagnosis/ Medical History:		

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"/>	

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

_____ is fit / unfit for participation in the
(Name of Client/Applicant)

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 : _____