

SPD HQ: 2 Peng Nguan Street, SPD Ability Centre, Singapore 168955

SPD@Tampines: Blk 866 Tampines St 83 #01-237, Singapore 520866

Enquiries: 6579 0764 / 6579 0765 / 6579 0749 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 needed ¹:

Children and Youth Services	
<input type="checkbox"/> Early Intervention Programme for Infants and Children (EIPIC) (age 0-6 years) – available at SPD@Tampines only	<input type="checkbox"/> Continuing Therapy (age 0-16 years) (Please tick √: <input type="checkbox"/> Physiotherapy <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Speech Therapy)
<input type="checkbox"/> Providing Access to Early Support (PACES) (age 3-6 years)	<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)
<input type="checkbox"/> Wellness Centre (centre-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)	
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

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

PARTICULARS			
Name:		NRIC No:	
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		
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: _____		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 or any 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: _____			

USAGE OF MOBILITY AIDS						
<input type="checkbox"/> No <input type="checkbox"/> Yes - If yes, please indicate the mobility aid use (*Delete where appropriate): <input type="checkbox"/> Wheelchair: Manual/Motorised* <input type="checkbox"/> Walking Frame <input type="checkbox"/> Rollator <input type="checkbox"/> Walking Stick/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						
Name	Age	Relationship	Staying Together Y/N	Marital Status	Occupation	Gross Salary
In case of emergency, to contact:						
Name: _____ Relationship: _____						
Contact No: _____						
APPLICANT/ REFERRING AGENCY						
Name/Signature: _____ Designation/Organisation: _____						
Tel: _____ Fax: _____ E-mail: _____						

ADDITIONAL INFORMATION

Please enclose the following relevant reports:

- Social Report, Occupational Therapist, Physiotherapist, Speech Therapist Assessment Reports
- Pay slips of immediate family members staying together and photocopies of the bank balances of applicant and spouse (if subsidy is required)

MEDICAL SUMMARY REPORT

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

Name: _____ NRIC No: _____

Diagnosis/ Medical History:		
<hr/> <hr/> <hr/> <hr/>		
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: (i) frequency: _____ (ii) 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 and 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 : _____