

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

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

Enquiries: 6236 6369 / 6236 6393 / 62366361 Email: [information@spd.org.sg](mailto:information@spd.org.sg) Website: [www.spd.org.sg](http://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<sup>1</sup>:

<b>Children and Youth Services</b>	
<input type="checkbox"/> Early Intervention Programme for Infants and Children (EIPIC) (aged 0-6 years) – available at SPD@Tampines only	<input type="checkbox"/> Continuing Therapy (age 0-16 years) (Please tick <input checked="" type="checkbox"/> : <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 students in mainstream schools (aged 6 years and above)
<b>Rehabilitation</b>	
<input type="checkbox"/> Adult and Geriatric Rehabilitation Centre (centre- based)	<input type="checkbox"/> Therapy @ Home (home-based)
<input type="checkbox"/> Wellness Centre (centre-based)	
<b>Day Care*</b>	
<input type="checkbox"/> Day Activity Centre	
<b>Vocational Skills and Training*</b>	
<input type="checkbox"/> Sheltered / Production Workshop	<input type="checkbox"/> IT Training/ Apprenticeship
<b>Technology*</b>	
<input type="checkbox"/> Assistive Technology	
<b>Social Support</b>	
<input type="checkbox"/> Social Support/ Counselling	<input type="checkbox"/> Caregiver Support

\* Services available at SPD HQ 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).

PARTICULARS			
<b>Name:</b>		<b>NRIC No:</b>	
<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:</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: _____  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)	
<b>Diagnosis:</b> _____			

USAGE OF MOBILITY AIDS						
<input type="checkbox"/> No <input type="checkbox"/> Yes - <i>If yes, please indicate the mobility aid use: (*Delete where appropriate)</i>						
<input type="checkbox"/> Wheelchair : Manual / Motorized*		<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
<b>In case of emergency, to contact:</b> 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: ~ 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		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 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 : \_\_\_\_\_