Society for the Physically Disabled

KINDLY FAX ALL REFERRALS TO: 6236 6378
Enquiries: 6579 0760
Email: information@spd.org.sg Website: www.spd.org.sg

DYSPHAGIA MANAGEMENT PROGRAMME

REFERRAL FORM

(This section may be filled up be 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		
Name:		**NRIC No:** IC Colour: ☐ S'pore / Pink ☐ S'pore Resident/ Blue ☐ Not available ☐ Others: _______________
Nationality:	**Gender:** ☐ Male ☐ Female	**Date of Birth/Age:**
Address:		
Telephone No: (H)	(HP)	(O)
E-mail Address:	**Marital Status:**	**Religion:**
Race: ☐ Chinese ☐ Malay ☐ Indian ☐ Others:__________	**Spoken Language:** ☐ English ☐ Mandarin ☐ Teochew ☐ Malay ☐ Cantonese ☐ Others: ☐ Tamil ☐ Hokkien __________	
Educational Level: ☐ No Formal Education ☐ Primary ☐ Secondary ☐ O Levels ☐ N Levels ☐ A Levels ☐ ITE Certificate in: ____________________ ☐ Diploma in: ____________________ ☐ Degree in: ____________________ ☐ Postgraduate in: ____________________	**Current / Last Employment (date):** **Housing Type:** ☐ Nil ☐ HDB Flat: _____ room rental / purchased ☐ Private Property - please state type: ____________________ ☐ Others: ____________________	

USAGE OF MOBILTY AIDS		
☐ **No** ☐ **Yes -** ***If yes, please indicate the mobility aid use:(*Delete where appropriate)***		
☐ Wheelchair : Manual / Motorized*	☐ Walking Frame	☐ Rollator
☐ Walking Stick / Quad stick*	☐ Others: ____________________	

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FAMILY INFORMATION

Name	Age	Relationship	Staying Together Y/N	Marital Status	Occupation	Gross Salary (applicable only if applying for subsidy)

In case of emergency, to contact:

Name: ____ Relationship: ___________________________________

Contact No: __________________________(H)_____________________(HP)____________________________(O)

APPLICANT/ CARE GIVER/ REFERRING AGENCY * *(delete where applicable)*

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)

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MEDICAL REFERRAL AND SUMMARY REPORT

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

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PARTICULARS		
Name:		**NRIC No:** IC Colour: ☐ S'pore / Pink ☐ S'pore Resident/ Blue ☐ Not available ☐ Others: ________________
Nationality:	**Gender:** ☐ Male ☐ Female	**Date of Birth/Age:**
Address:		
Telephone No: (H)	(HP)	(O)

NATURE OF DISABILITY		
☐ Physical Disability ☐ Intellectual Disability ☐ Developmental Disability	☐ Multiple Disabilities ☐ Psychiatric Disability ☐ Others: ________________	☐ Visual impairment: Partial / Total* ☐ Hearing impairment: Partial/ Total* *(*Delete where appropriate)*

Diagnosis/ Medical History:
____
____
____
____

Information Required	**Please tick☑ YES or NO**	**Please specify details, if available/ applicable**
Speech and hearing impairment	☐ ☐	
Visual Impairment	☐ ☐	
Infectious disease (e.g. TB, Hepatitis B, HIV, etc.)	☐ ☐	
History of Heart Disease (If applicable, please state the precautionary measures)	☐ ☐	Blood Pressure: ____________
History of Lung Disease (If applicable, please state the precautionary measures)	☐ ☐	
Has history of reactive airway disease/ asthma	☐ ☐	
Has problems with bladder and bowel function	☐ ☐	

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Has Diabetic conditions	☐	☐	
History of epileptic episodes, paralysis, seizure or other abnormality of the central nervous system.	☐	☐	If yes, pls state: ~ frequency: _______________ ~ last episode: ______________
History of mental illness e.g. depression / schizophrenia / bipolar disorders etc (If applicable)	☐	☐	
History of aggressive and violent behaviour	☐	☐	
Has swallowing dysfunction: on tube feeding/ gastrostomy	☐	☐	
Requires special diet or allergy to food	☐	☐	

Current Medication: Drug Allergy? ☐ No ☐ Yes (pls state:________________________)

1		3	
2		4	

Medical Follow Up: ☐ No ☐ Yes

	Hospital/ Clinic	**Name of Doctor**	**Date & Time**
1			
2			

Therapy History (Please attach Physiotherapy / Occupational Therapy / Speech Therapy reports if available).

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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/ gastrostromy).

____ ________________________

Signature and Name of Examining Medical Practitioner Date of Examination

Name and address of Clinic : ____

____

Contact No/ Email: ____