Headquarters
2 Peng Nguan Street
SPD Ability Centre
S (168955)

SPD@Jurong:
Blk 337 Jurong East Ave 1
#01-1562
S (600337)

SPD@Tampines:
Blk 866 Tampines St 83
#01-237
S (520866)

SPD@Toa Payoh
Blk 249 Kim Keat Link
#01-83
S (310249)

REFERRAL FORM

Please ensure ALL applicable sections of the form are completed.
SPD Hotline: 65790 700 Fax: 6236 6378
Email: information@spd.org.sg
SPD Website: www.spd.org.sg

Please tick the services needed:

CHILDREN SERVICES

- ❒ Continuing Therapy Programme (below 18 years old)
  - ❒ Occupational Therapy ❒ Speech Therapy
- ❒ Early Intervention Programme for Infants and Children (0 to 6 year old) – *Apply through SG Enable*
- ❒ Development Support Programme (3 to 6 years old) – *Apply through respective preschools*

ADULT AND ELDERLY SERVICES

Rehabilitation:

- ❒ Therapy Services* (18 years old and above)
  - ❒ Centre-based ❒ Home-based
  - ❒ Physiotherapy ❒Occupational Therapy ❒Speech Therapy

  **Apply through Agency for Integrated Care if subsidy is required*
- ❒ Day Activity Centre (16 years old – 55 years old)
- ❒ Day Care Centre (55 years old and above) – *Apply through Agency for Integrated Care*

Training & Employment:

- ❒ Vocational Training (IT related)
- ❒ Transition Programme for Employment
- ❒ Sheltered Workshop (16 years old and above)
- ❒ Employment Support (16 years old and above)

SPECIALISED SERVICES

- ❒ Assistive Technology
- ❒ Social Support
  - ❒ Counselling ❒ Caregiver Support ❒ Social & Financial Assistance
- ❒ School Integration Support (6 years old and above)

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SPD PRIVACY POLICY
SELF-DECLARATION FOR CLIENTS

I fully understand and agree that the personal information which I have provided, including my health, medical, social, financial information and photographs, may be disclosed to other agencies or individuals for the purposes as stated below. I trust that the information will strictly be used for the purpose stated:

a) For processing my application, including assessments and evaluations, for services, programmes and assistance offered by other organisations, in order to provide holistic support in my best interest;
b) For professional discussions between SPD and other agencies involved in the provision of my care, for the purpose of enhancing service delivery in my best interest;
c) For generating social, welfare, financial, regulatory, management or other related reports and performance of analytics. Personal data will be anonymised where possible or applicable;
d) To relevant government authorities, ministries, statutory boards, agencies or any person to whom disclosure is allowed or required by law, regulation or any other applicable instrument, for legal purposes;
e) For public education, advocacy, outreach, fund raising, and/or other related activities;
f) Any other purposes related to providing me with the necessary and relevant assistance for my situation.

I agree for SPD to contact me for any other purpose related to the services SPD is providing or had provided me with and/or matters which I have an on-going relationship with SPD.

If applicable:
This information has been translated to me in _____ (language) by

_____ (staff's name, designation/organisation)

on _____ (date).

_____	_____
Name of client*/caregiver/parent	Signature/Thumbprint & Date

**For minors below 21 years old, or clients above 21 years old and certified mentally incapacitated, consent will be obtained from parent and/or legal guardian on client's behalf.*

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Client's Particulars

Name: _____ Gender: ❒ Male ❒ Female

NRIC/Birth Cert: _____ [IC type: ❒ Pink ❒ Blue]

Date of birth: _____ (dd/mm/yyyy) Nationality: _____

Race: ❒ Chinese ❒ Malay ❒ Indian ❒ Eurasian ❒ Others: _____

Language spoken: ❒ English ❒ Mandarin ❒ Malay ❒ Tamil ❒ Dialect/Others: _____

Address: _____ Singapore ( )

Contact No: _____ (Home) _____ (Hp) _____ (Office)

Email Address: _____

Disability Type: ❒ Physical ❒ Sensory (Visual / Hearing*) ❒ Intellectual ❒ Developmental

Usage of Mobility/Visual/Hearing Device: ❒ No ❒ Yes (Pls specify: _____)

Able to travel by Public Transport independently: ❒ No ❒ Yes (Bus / MRT / Taxi*)

**Please delete accordingly*

Key Family Contact

Name: _____ Relationship to client: _____

Main Contact No.: _____ Language spoken: _____

Email Address: _____

Referral Source

Name: _____ Designation: _____

Organisation: _____ Contact No.: _____

Email Address: _____ Fax No.: _____

Date of Referral: _____

For Official Use

Referral received by: _____ _____
(Name of Staff, Department/Division Signature & Date

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MEDICAL SUMMARY REPORT

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

Name: _____ NRIC/Birth Cert No.: _____

Nature of Disability

☐ Physical Disability ☐ Multiple Disabilities ☐ Visual impairment
☐ Intellectual Disability ☐ Psychiatric Disability ☐ Hearing impairment
☐ Developmental Disability ☐ Others: _____

Medical History / Diagnosis / Description of difficulties:

_____

_____

_____

_____

Information Required	Please tick☑ YES or NO	Please specify details (if 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 Lungs Disease (If applicable, please state the precautionary measures)	☐ ☐	
Has history of reactive airway disease/ asthma	☐ ☐	
Problems with bladder and bowel Function	☐ ☐	
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	☐ ☐	

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Requires special diet or allergy to food	☐ ☐	

Current Medication: Drug Allergy? ☐ No ☐ Yes (please state:_____)

1		4	
2		5	
3		6	

Medical Follow Up: ☐ No ☐ Yes

	Hospital/ Clinic	**Name of Doctor**	**Date & Time**
1			
2			
3			

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

Other comments/observations/additional reason for referral:

RECOMMENDATION

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

Therapy Services / Day Care / Vocational Training Programmes *(please delete accordingly).*

_____ _____
Name & Signature of Examining Medical Practitioner Date

Name & Address of Clinic: _____

_____

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ANNEX A: FINANCIAL ASSESSMENT

This form should be completed if applying for financial assistance.

Name: _____ NRIC/Birth Cert No.: _____

1. FINANCIAL INFORMATION (Self and Immediate family members)

Name	Age	Relationship	Staying Together Y/N	Marital Status	Occupation	Gross Salary
					TOTAL GROSS FAMILY INCOME:	
					PCI:	

2. HOUSING INFORMATION

❒ HDB Flat

❒ Purchased ❒ Rental

❒ 1 – room ❒ 2 – room ❒ 3 – room ❒ 4 – room ❒ 5 – room

❒ Executive ❒ Maisonette ❒ Jumbo ❒ Executive Condominium

❒ Private

❒ Purchased ❒ Rental

❒ Private Condominium / Cluster Homes ❒ Landed Housing

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ANNEX B: EDUCATION & EMPLOYMENT BACKGROUND

This form should be completed if applying for training and employment services.

Name: _____ NRIC/Birth Cert No.: _____

1. Education Information

Current School / Level: _____

Highest Education Level:

❒ No Formal Education ❒ Primary ❒ Secondary

❒N' levels Passed ❒ O' levels Passed

❒ A' levels Passed

❒ ITE Certificate: _____

❒ Diploma: _____

❒ Degree: _____

❒ Postgraduate: _____

❒ Others: _____

2. Employment Information

Working Status:

❒ Currently working: _____
(Current job)

❒ Currently unemployed: _____
(Last employment / Date)

❒ Never been employed