

# AIC Referral Form (Centre-Based Services)



Common Fax: 6820 0730 (Pls call 6603 6931 if you have query on the status of faxes)

Official Reg No: \_\_\_\_\_ Date of fax received: \_\_\_\_\_ (for AIC input only)

Patient / family has consented to this application and to the disclosure of enclosed information to relevant agencies/service providers to facilitate the application. All personal information which you provide to us is subject to our Data Protection Policy (<https://www.aic.sg/data-protection-policy>).  Yes  No

## REFERRING SOURCE (i.e. person putting up this referral)

Name & Signature: \_\_\_\_\_ Designation / Institution: \_\_\_\_\_  
Contact no: \_\_\_\_\_ Email: \_\_\_\_\_

## CENTRE-BASED SERVICE TYPE

Day Rehabilitation (PT/OT)  Day Rehabilitation (ST)  Day Care  Dementia Day Care  Centre Based Nursing

## CLIENT'S PARTICULARS (affix patient identification label below if available)

Name : \_\_\_\_\_ NRIC/Passport/FIN/UIIN No : \_\_\_\_\_  
Citizenship :  Singaporean  Singapore PR  Not available  Others: \_\_\_\_\_  
Date of Birth (dd/mm/yyyy) : \_\_\_\_\_ Age: \_\_\_\_\_ Gender:  Male  Female  
NRIC Address : \_\_\_\_\_  
Residential Address : \_\_\_\_\_  
(If different from NRIC address)

## SOCIAL INFORMATION

Contact person: \_\_\_\_\_ Relationship to client: \_\_\_\_\_ Tel: \_\_\_\_\_  
Patient is known to MSW/ Case Manager/ Care Coordinator:  
 No  Yes (specify) Name: \_\_\_\_\_ Tel: \_\_\_\_\_

## PREFERENCES

Note: One Rehab conditions: Stroke, Musculoskeletal Conditions (MSK), Hip Fracture, Deconditioning, Spinal Cord Injury (SCI), Amputation

Is this client under One Rehab programme?  Yes  No Remarks : \_\_\_\_\_  
(if "Yes" is selected, pls indicate client's preferred referral destination or provider. If there is no preferred destination or provider, pls indicate "Nil")

Preferred Provider: \_\_\_\_\_  No preference

Diet (Day Care / Dementia Day Care only) :  No preference  Yes (specify): \_\_\_\_\_

Transport required? :  Yes  No

Escort required to bring patient to wait for transport? :  Yes  No

Note: Transport & Escort service are subjected to availability

Name of Patient: \_\_\_\_\_ NRIC: \_\_\_\_\_

**MEDICAL HISTORY: The person completing this section is responsible for the information submitted**

Please SKIP the respective section (indicate "see attached") if hospital discharge summary or medical memo or medication list is provided

**Summary of Medical Conditions / Problems:**

Is client diagnosed as dementia?:  Yes (Proceed to Type of Dementia)  No  Unsure

Type of Dementia:  Multi-Infarct / Vascular  Alzheimer's Disease  Others: \_\_\_\_\_

Cognitive & Behavioral Symptoms (if any): \_\_\_\_\_

**Note: Client referred to Dementia Day Care service must be diagnosed to be suffering from dementia by a SMC-registered Medical Practitioner**

**Does client currently have any active infectious disease?**

No  Yes (specify): \_\_\_\_\_ **Precaution:**  Standard  Contact  Others \_\_\_\_\_

**Are there any other precautions to be taken or conditions that would require closer monitoring?**

No  Yes (specify): \_\_\_\_\_

**MEDICATIONS** (Applicable only for Day Care or Dementia Day Care Service)

**Medications / Dosage / Frequency:**

Drug Allergies:  No  Yes (Specify): \_\_\_\_\_

**PARTICULARS OF DOCTOR OR HEALTHCARE PROFESSIONAL (AUTHORISED BY ORGANIZATION) COMPLETING MEDICAL HISTORY &/or MEDICATIONS SECTIONS**

Name & Signature: \_\_\_\_\_ Designation: \_\_\_\_\_

Institution: \_\_\_\_\_ MCR no. (for Doctor): \_\_\_\_\_

Contact no: \_\_\_\_\_ Email: \_\_\_\_\_ Date: \_\_\_\_\_

Name of Patient: \_\_\_\_\_ NRIC: \_\_\_\_\_

### CURRENT FUNCTIONAL STATUS

Please SKIP this section for client under One-Rehab programme and requires Day Rehab service only

**Mobility Status** :  Bedbound       Wheelchair       Ambulating (Proceed to Walking Aid)

Walking Aid :  N/A       Walking Stick / Umbrella       Quad Stick       Walking frame       Others: \_\_\_\_\_

**Assistance level** required for **wheelchair** or **ambulating**  
 Independent       Minimal Assist       Moderate Assist       Maximum Assist / Dependent

**Activity Tolerance** :  Poor (0 to < 15mins)       Fair (15 to 45 mins)       Good (> 45 mins)

**Transfers** :  Independent       Minimal Assist       Moderate Assist       Maximum Assist / Dependent

**Toileting** :  Independent       Needs Assistance       Dependent / Incontinent :  On diapers       Urinary catheter

### PROCEDURES (Applicable only for Centre Based Nursing Service)

Please SKIP this section (indicate "see attached") if nursing memo is provided

**Feeding tube** :  Ryle's tube       Flexiflo/kangaroo       Others, specify \_\_\_\_\_ Size: \_\_\_\_\_ Due for change on: \_\_\_\_\_

**Urinary Catheter** :  Indwelling       Suprapubic       Clean Intermittent Self Catheterization, specify frequency: \_\_\_\_\_

Type:  Latex       Silicon elastoma coated       Hydrogel coated       Silicone 100%

Size: \_\_\_\_\_ Due for change on: \_\_\_\_\_

**Wound** : Site: \_\_\_\_\_ Dressing Type: \_\_\_\_\_

Frequency of Change: \_\_\_\_\_ Date of last change: \_\_\_\_\_

**Stoma** :  Tracheostomy      Dressing due for change on: \_\_\_\_\_

PEG      Dressing due for change on: \_\_\_\_\_

Colostomy      Dressing due for change on: \_\_\_\_\_

Ileostomy      Dressing due for change on: \_\_\_\_\_

**Injection (IM / SC)** : Type:  IM       SC      Name of drug: \_\_\_\_\_ Dosage: \_\_\_\_\_

Frequency: \_\_\_\_\_ Date of last injection: \_\_\_\_\_

**Others** : \_\_\_\_\_