AIC Referral Form
(Home Care 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:** _____

HOME CARE SERVICE TYPE

Home Health Services:

Home Medical Service:
❑ Follow- up of chronic illness/ prescription of medication ❑ Others (specify): _____

Home Nursing Service:
❑ Procedure ❑ Health education/ monitoring of BP/ blood glucose
❑ Caregiver Training (specify): _____ ❑ Others (specify): _____

Home Therapy Service:
❑ Home Rehabilitation (Intensive) ❑ Home Based Exercise Training
❑ Home Environment Re view (Must be known to subsidized home care provider.)

Home Social Services:
❑ Meal-on-Wheels ❑ Medical Escort & Transport

Home Personal Care:
❑ Personal Hygiene ❑ Mind Stimulation Activities ❑ Elder-Sitting & Respite ❑ Assistance with other ADLs
❑ Assistance with IADLs ❑ Performing simple maintenance exercises prescribed by Registered Therapist

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

Name : _____

NRIC/Passport/FIN/UIN/No : _____

Date of Birth (dd/mm/yyyy) : _____**Age:**_____

NRIC Address : _____

_____

Residential Address : _____
(If different from NRIC address)
_____

Postal Code : _____

Telephone : _____

Accommodation : ❑ Private ❑ HDB (specify below)
❑1-Rm ❑2-Rm ❑3-Rm ❑4-Rm ❑5-Rm
❑Exec/Others

Housing : ❑ Purchased ❑ Rental ❑ Lodge

Lift-landing : ❑ Yes ❑ No

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

Gender:
❑ Male ❑ Female

Citizenship / IC colour:
❑ Singaporean / Pink ❑ Singapore PR / Blue
❑ Not available ❑ Others:_____

Marital Status:
❑ Single ❑ Married ❑ Widowed
❑ Separated ❑ Divorced

Religion:
❑ Buddhist ❑ Taoist ❑ Islam
❑ Hindu ❑ Christian ❑ Catholic
❑ None ❑ Others: _____

Current Location of Client:
❑ Home ❑ Hospital: _____ Ward/Bed: _____/_____

SOCIAL INFORMATION

Contact person: _____**Relationship to patient:**_____ **Tel:** _____

Patient is known to MSW/ Case Manager/ Care Coordinator:

❑ No ❑ Yes (specify) Name: _____**Tel:** _____

Name of Patient: _____ **NRIC:** _____

MEDICAL HISTORY (Applicable only for Home Health Services):
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 patient diagnosed as dementia?: ❑ Yes (Proceed to the Type of Dementia) ❑ No ❑ Unsure

Type of Dementia: ❑ Multi-Infarct/Vascular ❑ Alzheimer's Disease ❑ Others: _____

Cognitive & Behavioral Symptoms (if any): _____

Does patient 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

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:** _____

PREFERENCES

Preferred Provider: _____ **❑ No preference**

Name of Patient: _____ **NRIC:** _____

CURRENT FUNCTIONAL STATUS (Applicable only for Home Health Services)

Visual Impairment: ❑ No ❑ Yes _____

Hearing Impairment: ❑ No ❑ Yes _____

Mental Status: ❑ Rational ❑ Confused ❑ Unable to respond ❑ Others: _____

Mobility Status: ❑ Bedbound ❑ Wheelchair bound ❑ 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 Assistance ❑ Moderate Assistance ❑ Maximum Assistance

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

Transfers: ❑ Independent ❑ Minimal Assist ❑ Moderate Assist ❑ Maximum Assist / Total Dependent

Feeding: ❑ Independent ❑ Needs Assistance ❑ Dependent : ❑ Oral ❑ NG tube ❑ PEG

Toileting: ❑ Independent ❑ Needs Assistance ❑ Dependent / Incontinent : ❑ on diapers ❑ urinary catheter

Bowel Management: ❑ Continent ❑ Diapers ❑ Colostomy ❑ ileostomy ❑ Others _____

PROCEDURES (Applicable only for Home 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: _____

Name of Patient: _____ **NRIC:** _____

SIMPLIFIED ELIGIBILITY ASSESSMENT (PART 1)
(Applicable only for Meals On Wheels / Medical Escort & Transport/ Home Personal Care Service)

Please complete Q1 to Q15 AND the additional questions for specific service below:
MOW: Q16 –Q18, Q20 and Q30; MET: Q17 – Q21 and Q25 –Q30; HPC: Q21 – Q24 and Q27 – Q30

FUNCTIONAL STATUS

1. Does client need any supervision or help to move between locations on the same floor level?
Note : If person is self-sufficient using assistive devices, indicate as No.
0 – No 1 - Yes ☐

2. Does client need any supervision or help to manage personal hygiene?
Includes: Combing hair, brushing teeth, shaving, make-up, washing face or hands.
Excludes: Baths and showers
0 - No 1 - Yes ☐

3. Does client need any supervision or help to bathe or dress and undress below the waist?
Includes: Moving in and out of showers. For dressing/ undressing, includes street clothes, underwear, prostheses, belts, pants, skirts & shoes.
Excludes: Washing of back and hair.
0 - No 1 - Yes ☐

4. Does client have difficulty hearing (with hearing aid normally used)?
0 - No 1 - Yes ☐

5. Does client have difficulty seeing in adequate light (with glasses or with other visual appliance normally used)?
0 - No 1 - Yes ☐

HEALTH CONDITIONS

6. Does client sometimes feel short of breath when performing daily tasks?
Includes: Shortness of breath at rest or during normal daily activities
0 - No 1 - Yes ☐

7. Does client have any conditions that make his/ her health unstable?
Includes: Any disease or condition that causes fluctuating or unstable ADL, cognition, mood, or behavior, such as dementia, heart failure, gout and rheumatoid arthritis.
0 - No 1 - Yes ☐

8. Self-reported health: Ask: "In general, how would you rate your health?"
0 - Excellent/ Good 1 - Fair/ Poor 8 - Could not (would not) respond ☐

9. Self-reported mood: Ask: "In the last 3 days, have you felt sad, depressed or hopeless?"
0 – No 1 - Yes 8 - Could not (would not) respond ☐

COGNITION AND BEHAVIOUR

10. Does someone help client to make decisions about daily tasks?
Includes: When to get up, have meals, clothing, and activities.
0 - No 1 - Yes ☐

11. Ask client to remember 3 unrelated items (e.g. orange, pencil, chair) and let him/ her know you will ask about them again 5 min later. Can client recall after 5 min?

0 - Short-term Memory Ok 1 – Short-term Memory Problem 8 – Unable to Assess ☐

CAREGIVER

12. Does client have a caregiver?
0 - Yes, client stays with caregiver providing 24/7 care or care during the day
1 - Yes, client stays with caregiver who is not at home during the day
2 - No, client stays alone or has no caregiver ☐

13. If client has a caregiver, is the caregiver frail?
0 - No 1 – Yes 8 - NA ☐

14. Caregiver status - Caregiver reports feeling overwhelmed by client's illness
0 - No 1 – Yes 8 - NA ☐

15. If client has a caregiver, does the caregiver have difficulty doing the following for client?
0 – No 1 – Yes 8 - NA ☐

a. Prepare/ buy him meals? ☐
b. Go for appointments with him? ☐
c. Provide personal care for him? ☐

Name of Patient: _____ **NRIC:** _____

SIMPLIFIED ELIGIBILITY ASSESSMENT (PART 2)
(Applicable only for Meals On Wheels / Medical Escort & Transport/ Home Personal Care Service)

Please complete Q1 to Q15 AND the additional questions for specific service below:
MOW: Q16 –Q18, Q20 and Q30; MET: Q17 – Q21 and Q25 –Q30; HPC: Q21 – Q24 and Q27 – Q30

Functional Status

16. Does client need any supervision or help to prepare or buy his/ her meals? ☐
e.g. planning meals, assembling ingredients, cooking, setting out food and utensils
0 – No 1 - Yes

17. Does client need any supervision or help to manage a full flight of stairs? (12-14 steps) ☐
0 – No 1 - Yes

18. Does client need any supervision or help to travel by public transportation (navigating system, paying fare) or drive him/ herself (including getting out of house, into and out of vehicles)? ☐
0 – No 1 – Yes

19. Does client need any supervision or help to access the common corridor from his or her house? ☐
e.g. navigating stairs or kerb from house to common corridor
0 – No 1 – Yes

20. How does client move around in the community? ☐
0 – Independent 1 – Need quadstick/walking stick
2- Need wheelchair 3 – Bedbound

21. How easily can client transfer him/ herself from bed to chair and back? ☐
0 – Independent 1 – Need set-up help/ supervision/ limited assistance
2 - Need extensive to maximal assistance 3 – Bedbound

22. Can client use the toilet or commode and cleanse him/ herself after toilet use? ☐
0 – Independent 1 – Need set-up help/ supervision/ limited assistance
2 - Need extensive to maximal assistance 3 – Total dependence

23. Can client eat and drink on his/ her own? ☐
Note: Regardless of skill, including tube feeding
0 – Independent 1 – Need set-up help/ supervision/ limited assistance
2 - Need extensive to maximal assistance 3 – Total dependence

24. Does client need any supervision or help for ordinary work around the house? ☐
e.g. doing dishes, dusting, making bed, tidying up, laundry
0 – No 1 – Yes

25. Has client fallen in the last 90 days? ☐
0 – No 1 – Yes

26. Has client exhibited unsteady gait in the last 3 days? ☐
0 – No 1 – Yes

COGNITION AND BEHAVIOUR

27. Has client displayed any aggressive, socially inappropriate or disruptive behavior in the last 3 days? ☐
0 - Not present 1 – Present, but not exhibited in last 3 days
2 - Exhibited on 1-2 of last 3 days 3 - Exhibited daily in last 3 days

COMMUNICATION

28. Can client express information content? (includes both verbal & non-verbal expression) ☐
0 - Understood (expresses ideas without difficulty) 1 - Usually/ often understood
2 - Sometimes understood 3 - Rarely or ever understood

29. Can client understand information presented to him/ her? (however able; with hearing appliance normally used) ☐
0 - Understands (clear comprehension) 1 - Usually/ often understood
2 – Sometimes understood 3 - Rarely or never understood

30. Any other comments/information (e.g. infectious diseases, client preferences to note etc.)? _____