REFERRAL TO THE COMMUNITY PSYCHOGERIATRIC PROGRAMME (CPGP)

To expediate processing, please ensure that ALL applicable sections of the Referral Form are completed.
The outcome of the referral will be sent to the referral source

please circle accordingly

Referral & Enquiry Tel No: 68501840 / 68501841
Referral Form to be faxed to: 67873013
E - mail: CPGP@cgh.com.sg

Date of Referral: ______________________________

Name of Referring Doctor: ______________________________

Source of Referral: ☐ Polyclinic: ______________________________
(tick appropriate box)

☐ General Practitioner: ______________________________

☐ Hospital: ______________________________
(specify dept/ward/discipline)

☐ Others: ______________________________

Email Address of Referral Source: ______________________________
(for correspondence purposes)

Contact No: ____________________(Tel) ____________(Fax)

Address & Telephone No of Referral Source (for non CGH): ______________________________
(for correspondence purposes) ______________________________

Patient Details

Name: ______________________________

NRIC: ____________________

* PR/Work Permit Holder/Non - Resident (specify): ____________________

Date of Birth: ____________ Age: ________ Sex: *Male / Female

Address: ______________________________

Contact No: ____________ (Home) ____________(Mobile)

Race/Ethnic Group: ____________________ Religion ____________________

Dialect Group: ______________________ Language Spoken: ______________________

Preferred language: ______________________

Marital Status: *Single / Married / Divorced / Separated / Widowed

Education Level: * No formal education / Primary / Secondary / Vocational / Tertiary

Accomodation: * landed property / private apartment / HDB *1rm / 2rm / 3rm / 4 - 5rm / Exec/ Maisonette

Living Arrangement: * alone / with spouse or family / Nursing Home / with friends

Patient's current location:

☐ Home (specify address, if different from the above address)

____

☐ Institution (specify name, address & tel no)

____

Smoking: * Yes / No

Alcohol: * Yes / No

History of falls in last 12months: * Yes / No

No of falls in the last 12months: ______________

Medical Review after falls: * Yes / No

Remarks if any: ____

Current Financial Status

Current Employment: * Yes / No Occupation: ______________________

Previous Employment: * Yes / No Previous Occupation: ______________________

Main Income Source: * Salary / Savings / Public Assistance / Family / Friends / Others

(if others, please specify)____

Currently assisted by Social Service Agency: * Yes / No

Name of Social Service Agency: ____

Does the patient need Means Testing? * Yes / No

Family / Caregiver Details

Contact Person / Next of Kin: ____

Relationship: ______________________

Address (if different from patient): ______________________________

Contact No: ____________ (Home) ________________ (Mobile)

Language spoken: ______________________

Consent to CPGP Referral: * Yes / No

History of problems requiring referral & summary of relevant medical problems

Reason for Referral: ______________________________

Present Behaviour: ______________________________

Past Behaviour: ______________________________

Communication: * Communicative / Non communicative

Patient is currently or in the past on Psychiatric follow up? * Yes / No
if yes,please specify: ______________________________

Name of Psychiatrist: ______________________________

Hospital / Clinic: ______________________________

Psychiatric Illness: * Dementia / Dementia with BPSD / Alzheirmer's / Vascular Dementia / Depression / Anxiety / Psychosis / Others

Duration of symptoms: * less than a year / 1-2 years / 2-5years / more than 5 years

Current Psychiatric Medication: ______________________________

Drug Allergy: * No / Yes : ______________________________

Medical Illness: * Asthma / DM / CRF / CVA / COPD / Hyperlipidaemia / IHD / Hypertension / Others (specify):

Current Medication: ______________________________

Please remind patient to show all the medication during the first visit by CPGP team

Is patient currently receiving home medical / nursing or home help services? * Yes / No

If yes, please specify name, address, telephone no, fax no of the services: ______________________

____

Laboratory investigation, including radiological tests (with dates) - please attach report, if any:

____

____

Family history of Dementia / Psychiatric Illness / Neurological Disease: * Yes / No / Don't Know
If yes, specify illness: ______________________________

Current Mental Status (please circle)

Appearance: Kempt / Lethargic / Cachexic / Unkempt

Behaviour : Calm / Uncooperative / Suicidal / Aggressive

Mood : Normal / Irritable / Anxious / Depressed

Thought : Relevant / Irrelevant / Inconsistent / Delusional

Hallucination: * No / Yes (specify)

Memory - Immediate: Intact / Impaired Remote: Intact / Impaired

Orientation: Intact / Partially Intact / Disoriented

Suicide Potential: * Yes / No
If yes, please specify: ______________________________

Aggression Potential: * Yes / No

Sensory Functions

Speech: * Satisfactory / Slurred / Aphasic

Hearing: * Satisfactory / Partial Deafness / Total Deafness

Vision: * Satisfactory / Partially Impaired / Total Blindness

Current Functional Status

Mobility: * Independent / Needs Assistance / Chairbound / Bedbound

Feeding: * Independent / Needs Assistance (specify): Oral feeding / NG tube / PEG

Continence: * Yes / No (specify): on * catheter / diaper / others: ______________

Standing Ability: * Independent / Needs Assistance / Unable to stand

Pressure Sores: *No / Yes (specify site of sores): ______________

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Rehab Potential: * Good / Fair / Poor (specify reason) ______________________________

____

____

Social Background (please include genogram and attach Social report or Means Test, if available)

Significant family Issues: ____

____

____

Final Diagnosis: ____

Signature of referring doctor: ____________________ Date: ____________________

For Official Use

* Referral accepted / Rejected: ____

Referred To: ____

Referral Assessed by: ____________________________ Signature: ____________________

Date: ____

Reply to Referral Source: * Email / Mail / Telephone Call