

**SINGHEALTH COMMUNITY NURSING PROGRAMME (EAST)
REFERRAL FORM**

*REASON FOR REFERRAL
<input type="checkbox"/> Provide assessment and screening (includes providing referral for follow-up if necessary) Fall Prevention Programme Screening and Education Others (please specify) :
<input type="checkbox"/> Health coaching of resident / caregiver on chronic disease management Specify type of chronic diseases :
<input type="checkbox"/> Monitor chronic diseases (please specify type of chronic disease and monitoring required)
<input type="checkbox"/> Provide medication education and short-term medication packing
<input type="checkbox"/> Others (please specify) :
Additional remarks if any :

Exclusion criteria:

New acute symptoms, e.g. chest pain, severe shortness of breath

Requiring long-term clinical procedures e.g. wound dressing, change of tubes etc.

Suspected elder abuse

If there is suspicion of cognitive impairment, please obtain consent for service from main spokesperson.

REFERRING SOURCE	
*Organisation :	
*Name/Designation :	*Contact No :
*Referral Date :	Email Address:

REGISTRATION INFORMATION	
*Name :	
*NRIC:	
*Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Nationality: <input type="checkbox"/> Singaporean <input type="checkbox"/> Permanent Resident
D.O.B.	*Age:
*Address:	*Contact Number:
*Language Spoken:	<input type="checkbox"/> English <input type="checkbox"/> Mandarin <input type="checkbox"/> Malay <input type="checkbox"/> Tamil <input type="checkbox"/> Cantonese <input type="checkbox"/> Hokkien <input type="checkbox"/> Teochew <input type="checkbox"/> Hakka <input type="checkbox"/> Others:
Housing:	<input type="checkbox"/> 1 Rm HDB <input type="checkbox"/> 2 Rm HDB <input type="checkbox"/> 3 Rm HDB <input type="checkbox"/> 4 Rm HDB <input type="checkbox"/> 5 Rm HDB <input type="checkbox"/> Executive / HDB Maisonette <input type="checkbox"/> HUDC/Condominium <input type="checkbox"/> Landed
Living Arrangement:	<input type="checkbox"/> Alone <input type="checkbox"/> Spouse <input type="checkbox"/> Children <input type="checkbox"/> Friend <input type="checkbox"/> Maid Remarks:
Main Carer:	<input type="checkbox"/> Spouse <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Maid <input type="checkbox"/> Friend <input type="checkbox"/> Self <input type="checkbox"/> Others:
Main Spokesperson (if applicable):	
Name:	
Relationship:	
Contact Number:	
Financial Scheme:	<input type="checkbox"/> CHAS (Blue/Orange/Green) <input type="checkbox"/> PA <input type="checkbox"/> MFEC <input type="checkbox"/> Others:
*Verbal Consent for CGH Community Nursing Service: <input type="checkbox"/> Yes <input type="checkbox"/> No	

*** Mandatory Fields**

Please email the complete form to community_nursing@cgh.com.sg