Changi General Hospital
SingHealth

Community PsychoGeriatric Programme

REFERRAL TO THE COMMUNITY PSYCHOGERIATRIC PROGRAMME (CPGP)

To expediate processing, please ensure that ALL applicable sections of the Referral Form are completed.
*Please tick/circle accordingly.

Referral & Enquiry Tel No: **69365793**. Referral Form to be faxed to: **67873013**. Email: CPGP@cgh.com.sg

CPGP Enrolment criteria:
Age >> 65 years & above with mental disorder(s). Younger patients must have a diagnosis of Dementia.
Unable to access hospital services
Residing within Singhealth boundary
Service is chargeable. Financial assistance card holder e.g. CGH Medifund, MFEC/MFAC & PA are acceptable.
CHAS & PG card are not applicable for this service

REFERRAL SOURCE			
Name of referring doctor or personnel:		Referral date	
Email address:		Telephone no	
Source of referral	☐	Polyclinic:	
	☐	General practitioner:	
Please attach discharge summary	☐	Hospital **(specify dept/ward/discipline & contact no):**	
	☐	Others:	

PATIENT'S DEMOGRAPHIC			
Name:		Date of Birth:	
NRIC:		Age:	
PR/ Work permit holder/ non-resident specify)		Race:	
Address:			
Residential telephone:		Sex:	* Male/ Female
Mobile telephone:		Language Spoken:	
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 arangement:	* alone/ with spouse or family/ Nursing home/ with friends/ with maid		
Visiting address (if different from NRIC			

PATIENT'S FAMILY/ CAREGIVER DETAILS			
Contact Person/ Next of kin:		Relationship:	
Residential Telephone:		Mobile:	
Language spoken:		NOK's name who consented to CPGP referral	

PATIENT'S HISTORY & MEDICAL BACKGROUND SUMMARY	
Reason for referral:	
Community Ambulant	*Yes / No If yes, please state reason for referral:
Patient is currently or has been on psychiatric follow-up:	* Yes/ No
If yes, please specify:	
Name of psychiatrist:	
Hospital/clinic:	
Psychiatric illness:	
Current psychiatric medication:	
Drug allergy:	
Medical illness:	

RISK ASSESSMENT	
Suicide Potential: If yes please elaborate	* Yes/No
Aggression potential: If yes please elaborate	* Yes/No

PATIENT'S SOCIAL BACKGROUND (please include genogram and attach Social Report or Means Test, if available) Please state if patient is receiving support from any social agency)			
Significant family issues:			
Signature of referring doctor or personnel		Date:	

FOR OFFICIAL USE	
Referral:	* Accepted/ Rejected
Referral assessed by:	

Signature:		Date:	