Changi General Hospital

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: 64267511. Referral Form to be faxed to: **67873013**. Email: CPGP@cgh.com.sg

REFERRAL SOURCE				
Name of referring doctor:			Referral date	
Email address:			Telephone	
Mailing address (for non CGH staff):			Fax No.	
Source of referral	☐	Polyclinic:		
	☐	General practitioner:		
	☐	Hospital (specify dept/ward/discipline):		
	☐	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:		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 arangement:	* alone/ with spouse or family/ Nursing home/ with friends/ with maid		

Patient's current location:	☐	Home (specify name,address & tel no):		
	☐	Institution (specify name,address & tel no):		
Smoking:	* Yes/ No		Alcohol:	* Yes/ No
History of falls in last 12 months:			Number of falls in last 12 months:	
Medical review after falls:	* Yes/ No		Remarks:	

PATIENT'S CURRENT FINANCIAL STATUS					
Current employment:	Yes / No		Previous employment:	Yes / No	
Current Occupation:			Previous occupation:		
Main income source:	* Salary/ Savings/ Public assistance/ Family/ Friends/ Others (pls specify)				
Currently assisted by Social Service Agency:	* Yes/ No		Does patient require Means Testing?	* Yes/ No	
Name of Social Service Agency:					
Services provided by Social Service Agency					
PA cardholder:	* Yes/ No	Card No:		Card Exp date:	

PATIENT'S FAMILY/ CAREGIVER DETAILS			
Contact Person/ Next of kin:		Relationship:	
Address (if different from patient):			
Residential Telephone:		Mobile:	
Language spoken:		NOK's name who consented to CPGP referral	

PATIENT'S HISTORY & MEDICAL BACKGROUND SUMMARY	
Reason for referral:	
Present behaviour:	
Past behaviour:	
Patient is communicative:	* Yes/ No
Patient is currently or has been on psychiatric follow-up:	* Yes/ No
If yes, please specify:	
Name of psychiatrist:	
Hospital/clinic:	
Psychiatric illness:	
Duration of symptoms:	* less than 1 year/ 1- 2 years/ 2 - 5 years/ more than 5 years
Current psychiatric medication:	
Drug allergy:	
Medical illness:	
Current medication:	

Please remind patient to show all medications during initial visit by CPGP team

Patient is currently receiving home medical/ nursing or home help services:		* Yes/ No
If yes, please specify contact details (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:		

PATIENT'S CURRENT MENTAL STATUS			
Appearance:	* Kempt / Lethargic / Cachexic / Unkempt		
Behaviour:	* Calm / Uncooperative / Suicidal / Aggressive		
Mood:	* Normal / Irritable / Anxious / Depressed		
Thought:	* Relevant / Irrevalent / Inconsistent / Delusional		
Hallucination:	* Yes/No		
If yes, please specify:			
Immediate memory:	* Intact / Impaired	Remote memory:	* Intact / Impaired
Orientation:	* Intact / Partially Intact / Disoriented		
Suicide Potential:	* Yes/No		
If yes, please specify:			
Aggression potential:	* Yes/No		

PATIENT'S SENSORY FUNCTION	
Speech:	* Satisfactory / Slurred / Aphasic
Hearing:	* Satisfactory / Partial Deafness / Total Deafness
Vision:	* Satisfactory / Partial Impaired / Total Blindness

PATIENT'S 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:	* Yes/ No
If yes, please specify sites of sores	
Rehab potential:	* Good/ Fair/ Poor
If poor, please specify reason	

PATIENT'S 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		
Referral assessed by:			
Signature:		Date:	
Reply to Referral Source:	* Email/ Mail/ Telephone call		