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<br>(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 | | |