Health Wellness Programme Referral Form

EASTERN COMMUNITY HEALTH CENTRE

For Appointment,
Eastern CHC (Tampines)
Tel: 6782 6885 Fax: 6782 9591

PATIENT'S PARTICULARS (or affix patient's label)

Name: ____________________

NRIC: ____________________

Date of Birth: ____________________ Gender: F / M

Language(s) Spoken: ○ English ○ Malay ○ Mandarin ○ Tamil ○ Others: ____________

Address: ____________________

____________________ Contact No.: ____________

Date of Appointment: ____________________

Time of Appointment: ____________________

SERVICES REQUESTED (by appointment only)

- ○ Anger Management
- ○ Grief Therapy
- ○ Lifestyle Behaviour Modification
- ○ Medication Adherence
- ○ Relapse Prevention
- ○ Sleep Hygiene for Insomnia
- ○ Stress Management
- ○ Supportive Counselling
- ○ Understanding Mental Illness
- ○ Others: ____________

Remarks: ____________________

PATIENT'S MEDICAL BACKGROUND

Psychiatric Diagnosis & Date of Diagnosis:

____

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Current Psychiatric Medications: ____________________

Global Assessment of Functioning (GAF) Score: ____________________

Medical Conditions: ○ Diabetes ○ Hypertension ○ Hyperlipidaemia ○ Others: ____________

Current Medications: ____________________

Referral Clinic (Clinic Stamp with Tel and Fax):

Name of Doctor: ____________________

MCR No.: ____________________

Signature: ____________________

Date: ____________________

Operating Hours (By appointment only)
Monday to Friday
8.30 am to 12.00 pm
1.00 pm to 5.00 pm

Eastern Community Health Centre (Tampines)
Our Tampines Hub, 1 Tampines Walk,
#03-33, Singapore 528523
Tel: 6782 6885 Fax: 6782 9591

(Updated December 2019)