Changi General Hospital
SingHealth

Restricted, Sensitive (High)

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		

Accommodation:	* landed property/ private apartment/ HDB *1rm/ 2rm/ 3rm/ 4-5rm/ Exec/ Maisonette
Living arrangement:	* alone/ with spouse or family/ Nursing home/ with friends/ with maid
Visiting address (if different from NRIC address)	

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:	