Changi General Hospital
SingHealth

SINGHEALTH COMMUNITY NURSING PROGRAMME (EAST)
REFERRAL FORM

*REASON FOR REFERRAL
☐ **Provide assessment and screening** (includes providing referral for follow-up if necessary) Fall Prevention Programme Screening and Education Others (please specify) : ☐ **Health coaching of resident / caregiver on chronic disease management** Specify type of chronic diseases : ☐ **Monitor chronic diseases** (please specify type of chronic disease and monitoring required) ☐ **Provide medication education and short-term medication packing** ☐ **Others** (please specify) :
Additional remarks if any :

Exclusion criteria:
New acute symptoms, e.g. chest pain, severe shortness of breath
Requiring long-term clinical procedures e.g. wound dressing, change of tubes etc.
Suspected elder abuse

If there is suspicion of cognitive impairment, please obtain consent for service from main spokesperson.

REFERRING SOURCE	
***Organisation :**	
***Name/Designation :**	***Contact No :**
***Referral Date :**	**Email Address:**

REGISTRATION INFORMATION					
***Name :** ***NRIC:** ***Gender:** ☐ Male ☐ Female **D.O.B.** ***Address:**			**Nationality:** ☐Singaporean ☐Permanent Resident ***Age:** ***Contact Number:**		
***Language Spoken:**	☐English ☐Hokkien	☐Mandarin ☐Teochew	☐Malay ☐Hakka	☐Tamil ☐Others:	☐Cantonese
Housing:	☐1 Rm HDB ☐Executive / HDB Maisonette	☐2 Rm HDB	☐3 Rm HDB ☐HUDC/Condominium	☐4 Rm HDB	☐5 Rm HDB ☐Landed
Living Arrangement:	☐Alone Remarks:	☐Spouse	☐Children	☐Friend	☐Maid
Main Carer:	☐Spouse ☐Self	☐Son ☐Others:	☐Daughter	☐Maid	☐Friend
Main Spokesperson (if applicable): Name: Relationship: Contact Number:					
Financial Scheme:	☐CHAS (Blue/Orange/ Green)	☐PA	☐MFEC	☐Others:	
***Verbal Consent for CGH Community Nursing Service:**		☐Yes		☐No	

*** Mandatory Fields**

Please email the complete form to community_nursing@cgh.com.sg