



LIONS BEFRIENDER SERVICE ASSOCIATION (SINGAPORE)

Blk 130 Bukit Merah View #01-358 Singapore 150130

Tel: 6375 8600 Fax: 6273 1500

Website: <http://www.lionsbefrienders.org.sg>

CASE REFERRAL/REGISTRATION FORM

I. PARTICULARS OF CLIENT					
NRIC (*Pink <input type="checkbox"/> / Blue <input type="checkbox"/> / Others <input type="checkbox"/>): No.					
Name (* Mr <input type="checkbox"/> / Mrs <input type="checkbox"/> / Mdm <input type="checkbox"/> / Ms <input type="checkbox"/>):					
Type of Case: (* PA <input type="checkbox"/> / OR <input type="checkbox"/> / ORP <input type="checkbox"/>)			PA No.(if applicable):		
Date of Birth: / /		Age:	Country of Birth:		
Race (* CH <input type="checkbox"/> / ML <input type="checkbox"/> / IN <input type="checkbox"/> / OT <input type="checkbox"/> / ER <input type="checkbox"/>)			Religion:		Tel:
Sex: (* M <input type="checkbox"/> / F <input type="checkbox"/>)	Marital Status: (* S <input type="checkbox"/> / M <input type="checkbox"/> / D <input type="checkbox"/> / W <input type="checkbox"/>)		Occupation:		
II. HOME ADDRESS					
Street:				Postal Code:	
Blk No.:	Floor No.:	Unit No.:	Type: (* Rented <input type="checkbox"/> / Purchased <input type="checkbox"/> (* 1 <input type="checkbox"/> / 2 <input type="checkbox"/> / 3 <input type="checkbox"/> / 4 <input type="checkbox"/> / 5 <input type="checkbox"/>)		
Known by other VWOs? (* Y <input type="checkbox"/> / N <input type="checkbox"/>)		If yes, please specify:			
III. ADDITIONAL INFORMATION					
Language/Dialect Spoken: <input type="checkbox"/> English <input type="checkbox"/> Mandarin <input type="checkbox"/> Malay <input type="checkbox"/> Tamil <input type="checkbox"/> Hokkien <input type="checkbox"/> Teochew <input type="checkbox"/> Cantonese <input type="checkbox"/> Hakka <input type="checkbox"/> Others					
Highest Education Received:			Living Pattern:		
Mobility:			Monthly Household Income: \$		
Hearing Capability:		Eyesight:		Financial Assistance: (* Y <input type="checkbox"/> / N <input type="checkbox"/>)	
Reading Glasses: (* Y <input type="checkbox"/> / N <input type="checkbox"/>)		Cataract / Glaucoma: (* Y <input type="checkbox"/> / N <input type="checkbox"/>)		Hearing Aid: (* Y <input type="checkbox"/> / N <input type="checkbox"/>)	
In case of Emergency, contact (Name/Relationship/Tel):					
Remarks:					
Family Background:					

Home/Living Condition:	
Vulnerability Elaboration:	
Financial Status:	
IV. FOR OFFICIAL USE	
Date assessed: / /	Status: <input type="checkbox"/> Approved <input type="checkbox"/> Not Approved
	<input type="checkbox"/> New <input type="checkbox"/> Reinstated Case
Staff-in-charge:	Classification: (* VS <input type="checkbox"/> /NVS <input type="checkbox"/>)
Reason(s):	
Plan of Action: (* Befriending Service <input type="checkbox"/> / Information & Referral <input type="checkbox"/>)	
Referred to:	
for: (* Counselling <input type="checkbox"/> / Financial Assistance <input type="checkbox"/> / Home Help <input type="checkbox"/> / Rations <input type="checkbox"/> / Others <input type="checkbox"/>)	
If others, please specify:	
Other Remarks:	
1st Visit On: _____ at _____ - _____	
2nd Visit On: _____ at _____ - _____	
3rd Visit On: _____ at _____ - _____	
Date of Closure:	Staff:
Reason(s) for closure:	

***please tick where applicable**

V. SOURCE OF REFERRAL		
Referring Organisation:		
Contact No:	Fax:	Email:
Referring Person:	Date of Referral: / /	
Designation:		