CONFIDENTIAL

BEFRIENDING CASE REFERRAL/REGISTRATION FORM (Fax: 6273 1500)

NRIC/FIN No*_____ ☐ Pink ☐ Blue

Name

Personal Particulars

Gender ☐ Male ☐ Female	**Date of Birth (DD/MM/YYYY)**	**Age**	**Place of Birth**	**Nationality**

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed	**Race** ☐ Chinese ☐ Malay ☐ Indian ☐ Others _____	**Religion**

Family Type/Living Pattern ☐ Live alone ☐ With flatmate ☐ With domestic helper ☐ With family (children/parent/relative/sibling/spouse*) ☐ Others _____	**Dietary Preference** ☐ Chinese ☐ Vegetarian ☐ Halal ☐ Others _____
	Spoken Language ☐ English ☐ Mandarin ☐ Malay ☐ Tamil ☐ Cantonese ☐ Hokkien ☐ Teochew ☐ Others _____

Home Ownership/Flat Type ☐ HDB Rental ☐ HDB Purchased ☐ Private **No of Rooms** ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ Others	**Contact No** ☐ Home ☐ HP

Address

Financial Information

Financial Support	**Assistance Type** ☐ PA ☐ ComCare ☐ Medifund ☐ N.A. (Rely on Savings) **PA No.: _____** **Amt/monthly ($): _____** **ComCare/Medifund Period of Assistance: _____**	**Other Sources of Support:** *E.g. family, religious groups, foundations etc.* **Source/Amt ($)_____** **Source/Amt ($)_____**

Health Information

Mobility/Mobility Aid	☐ Ambulant ☐ Semi-ambulant ☐ Wheelchair-bound ☐ Bedbound ☐ Does not use Aids ☐ Walking Stick/Frame ☐ Manual/Electric Wheelchair	
Medical Condition(s) *E.g. Chronic disease, Dementia, Depression, etc.*	**List medical condition(s):** ☐ High Blood Pressure ☐ High Cholesterol ☐ Diabetes ☐ Heart Disease **Any other medical condition(s) or information:**	
	Compliance to medication ☐ Yes ☐ No ☐ Irregular (**Reasons**:_____)	**Known to which hospitals/polyclinic**

Emotional observation during assessment	Did Client appear depressed, display any mood swing/emotional distress E.g. nervousness, anxiety, crying, etc.? ☐ Yes ☐ No		
Cognitive observation during assessment	Is the client able to express himself coherently? ☐ Yes ☐ No Does the client appear to be forgetful in the course of conversation? ☐ Yes ☐ No		
Hearing Ability	☐ Good ☐ Fair ☐ Hard of Hearing ☐ Deaf	**Using Hearing Aid** ☐ Yes ☐ No	
Eyesight	☐ Good ☐ Fair ☐ Poor ☐ Blind	**Cataract (L/R*) Glaucoma (L/R*)** ☐ Yes ☐ No ☐ Yes ☐ No **(Operated/Not Operated*)**	**Reading Glasses** ☐ Yes ☐ No

Social Support/Living Conditions

Family Background

☐ No. of Siblings: ____ (___Brothers, ___Sisters) ☐ No of Children ____ (_____ Sons, _____ Daughters)

☐ Other Next of Kin: _____

Contact Frequency by Family/Friends	**Contact with (relationship):_____** ☐ None ☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly ☐ Ad hoc ☐ Others: _____ **Contact with (relationship):_____** ☐ None ☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly ☐ Ad hoc ☐ Others: _____

Emergency Contact Person **NOK if possible*

Name: Relationship:

Contact No (Home): (HP):

Home Living Condition **multiple ticks allowed*

☐ Neat ☐ Cluttered ☐ Clean ☐ Dirty ☐ Bug infested

☐ Equipped with home safety devices e.g. toilet grab-bars ☐ Furnishing (Bare/Basic/Well-equipped*)

Community Support **state agencies or individuals supporting client e.g. Neighbours, Friends, SACs, Other Services, e.g. counselling, home help, rations, etc.*

☐ Attends SAC/Religious places of worship _____ *(name)* _____ *(freq.)*

☐ Meals Delivery by _____ ☐ Housekeeping/Laundry by _____

☐ Escort Service by _____ ☐ Day Care/Counselling by _____

☐ Personal Hygiene by _____ ☐ SSO/FSC/Cluster Support by _____

☐ Home Medical/Nursing by _____ ☐ Others _____

*Please attach with previous sheet.

Name of Client: _____ NRIC/FIN No. _____

What does Client do to pass time?	**Client Interests**
Preferred Day & Time of Home Visit	**Other information of client**

Source of Referral

Referral Date	**Referral Person** **Designation**	**Referring Organisation**

Contact No	**Fax No**	**Email**

Remarks

FOR OFFICIAL USE

Date assessed	**Assessed by**	**If Uncontactable, please state visit date** ☐ 1st Visit Date ☐ 2nd Visit Date ☐ 3rd Visit Date / / / / / /

Referral Status

☐ Pending ☐ Approved ☐ Rejected

☐ Uncontactable ☐ Existing Befriendee

Classification

☐ Tier 1 ☐ Tier 2 ☐ Tier 3 ☐ Tier 4

Rejected Reason

☐ Does not meet criteria ☐ Rejected Service

☐ Hospitalised/Institutionalised * ☐ Passed Away

Declaration

☐ **Senior who <u>rejects</u> service during assessment**

I understand the services which have been explained to me but I do not want any befriending service from Lions Befrienders.

☐ **Senior who <u>accepts</u> service**

I agree to receive befriending service from Lions Befrienders and the terms of service mentioned below.

Terms of Service **to be explained to Senior*

<u>Use of personal data and photographs</u>

I give consent for LBSA to release relevant information when required by Social Service Agencies or Sponsors so that I can receive necessary referred services and benefits for activities.

I give consent for LBSA to use my personal data, photographs and videos taken in the course of receiving services from LBSA, for publicity or source of Research in LBSA. However, LBSA shall request for additional consent to individual media interviews/requests.

<u>Suspension and Termination of Befriending Service</u>

I understand that LBSA will suspend befriending service to seniors who have been hospitalised for an extended period of time. In the event senior is institutionalized or upon death, LB will terminate the befriending service.

**For the safety and respect of an abuse-free environment for our staff & volunteers, seniors who display repeated disciplinary behavior, may be suspended if multiple chances & verbal warnings have not been heed.*

Signature: **Date:**

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