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BEFRIENDING CASE REFERRAL/REGISTRATION FORM (Fax: 6273 4521)

Email address: befriending@lb.org.sg

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.

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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

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

Referral Status	Rejected Reason
☐ Pending ☐ Approved ☐ Rejected ☐ Uncontactable ☐ Existing Befriendee	☐ Does not meet criteria ☐ Rejected Service ☐ Hospitalised/Institutionalised * ☐ Passed Away
Classification ☐ Tier 1 ☐ Tier 2 ☐ Tier 3 ☐ Tier 4	

Declaration

☐ **Senior who rejects 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 accepts 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*

Use of personal data and photographs

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

Suspension and Termination of Befriending Service

I understand that LB 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:**