LIONS BEFRIENDERS CLUSTER SUPPORT REFERRAL/REGISTRATION FORM

Clementi/Bukit Timah: cbt.cs@lb.org.sg
Queenstown: qtn.cs@lb.org.sg
Tampines/Changi: tpn.cs@lb.org.sg

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Part 1 – Referral Information

Referral Date	**Referral Person**	**Designation**
Referring Organisation	**Contact/Fax No**	**Email**

[ ] **Discharge Summary** *[if applicable]*	**Has Client/Family consented to this application and to the disclosure of enclosed information to relevant agencies/service providers to facilitate the application?** [ ] Yes [ ] No

Part 2 - Client Personal Particulars *[Tick the Appropriate Option]*

Name:		**NRIC No.:** [ ] Pink [ ] Blue	
Gender [ ] Male [ ] Female	**Date of Birth** (DD/MM/YYYY)	**Age**	**Nationality**
Address: **Flr:** **Unit No:** **Postal Code:**			**Contact No** [ ] Home: [ ] HP:
Race [ ] Chinese [ ] Malay [ ] Indian [ ] Others _____	**Marital Status** [ ] Single [ ] Married [ ] Divorced [ ] Separated [ ] Widowed		**Religion** [ ] Buddhism [ ] Christianity [ ] Hinduism [ ] Islam [ ] None [ ] Others _____

Family Type/Living Pattern

[ ] Live alone
[ ] With flatmate
[ ] With domestic helper
[ ] With family (children/parent/relative/sibling/spouse*)
[ ] Others _____

Home Ownership/Flat Type

[ ] Rental [ ] Purchased [ ] Private

No of Rooms [ ] 1 [ ] 2 [ ] 3 [ ] 4 [ ] 5 [ ] Others

Spoken Language

[ ] English [ ] Mandarin [ ] Malay [ ] Tamil [ ] Cantonese
[ ] Hokkien [ ] Teochew [ ] Hainanese [ ] Hakka
[ ] Others _____

Part 3 – Client Health/Social & Financial Information

Presenting Issues

Social Care Needs

[ ] Befriending
[ ] Group Activities

Health Care Needs

[ ] House Keeping [ ] Home Nursing [ ] Home Medical
[ ] Medical Escort [ ] Personal Hygiene

Mobility	[ ] Ambulant [ ] Semi-ambulant [ ] Wheelchair [ ] Bedbound [ ] Fall Risk [ ] Walking Stick [ ] Quad Stick [ ] Walking Frame [ ] Does not use Aids
Bathing/Dressing/Feeding*	[ ] Independent [ ] Needs Help
Toileting	[ ] Independent [ ] Commode [ ] On Diapers [ ] Urinary Catheter [ ] Others
Transferring	[ ] Independent [ ] Needs Help

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*)

Cognitive Ability

[ ] Appears Confused [ ] Appears Forgetful [ ] Normal [ ] Others _____

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Name of Client: _____ NRIC/FIN No: _____

Medical condition(s):
[ ] Hypertension [ ] Hyperlipidemia [ ] Diabetes [ ] Heart Disease [ ] Dementia [ ] Depression
Any other medical condition(s) or information:

Compliance to medication [ ] Yes [ ] No [ ] Irregular
Reasons:

Known to which hospitals/polyclinic

Frequency of follow up, if any.

Hearing Ability
[ ] Good [ ] Fair [ ] Hard of Hearing [ ] Deaf

Using Hearing Aid
[ ] Yes [ ] No

Eyesight
[ ] Good [ ] Fair [ ] Poor [ ] Blind

Reading Glasses
[ ] Yes [ ] No

Cataract (L/R*)
[ ] Yes [ ] No
(Operated / Not Operated*)

Glaucoma (L/R*)
[ ] Yes [ ] No

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

[ ] Attends SAC _____ *(name)* _____ *(freq.)*

[ ] Religious places of worship _____ *(name)* _____ *(freq.)*

[ ] Meals Delivery by _____ [ ] Housekeeping/Laundry by_____

[ ] Medical Escort by _____ [ ] Day Care/Counselling by_____

[ ] Personal Hygiene by _____ [ ] SSO/FSC/Cluster Support by_____

[ ] Home Medical/Nursing by _____ [ ] Others _____

Family Background

[ ] No. of Siblings: _____

[ ] 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: _____

Caregiver

Name:

Relationship:

Contact (Home): (HP):

Emergency Contact Person (if different from caregiver)

Name:

Relationship:

Contact (Home): (HP):

Financial Assistance

[ ]PA [ ] ComCare [ ] Medifund [ ] Silver Support Scheme

[ ] Medical Fee Exemption Card (MFEC) [ ] None

PA No.: _____

Amt/month ($): _____

ComCare/MediFund Period of Assistance: _____

Other Sources of Financial Support:
E.g. family, religious groups, foundations etc.

Source/Amt ($)_____

Source/Amt ($)_____

Proposed Follow-up Actions for Referred Client