THYE HUA KWAN MORAL CHARITIES

Rehabilitation Referral Form

Functional Status Checklist:

1. Pain
* Is the client/ patient experiencing any pain in their body? If yes, which part \_\_\_\_\_\_\_
1. Fall
* Did the client/patient have any fall in the past 1 year?
1. ADL/ Mobility

Does the client/ patient have difficulty in:

* Self-Feeding
* Bathing
* Toileting
* Getting up from bed
* Walking
* Climbing stairs
1. Swallowing

Does the client/ patient report of:

* Eating/ Swallowing difficulty
* Unexplained weight loss
* Prolonged meal time
* Coughing and/or choking episode on food and/or drinks
1. Community
* Does the client/ patient have difficulty walking in the community (slopes/stairs/steps)?
* Does the client/ patient have difficulty buying things/ grocery/shopping?
* Does the client/ patient have difficulty taking public transport?
* Does the client/ patient feel tired easily when you out in the community?
* Does the client/patient frequently misuse/forget words or have difficulty expressing himself/herself (e.g. word finding difficulty, slurring of speech, changes in voice)?
1. Others reasons for referral:
* Severe Disability Assessment
* CAF Assessment (for people with Autism Spectrum Disorder (ASD) or Intellectual Disability (ID))
* Home Modification Assessment
* Senior Mobility Fund Application
* Weight Management
* Post surgical rehabilitation (i.e., Total Knee Replacement)

***If the client/patient has any needs above, please refer for rehab by filling page 2.***

Patient / Family has consented to this application and to the disclosure of enclosed information to relevant agencies / service providers to facilitate the application. Yes / No

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| **SERVICE REQUIRED** |
| * **Day Rehabilitation** (Active rehabilitation / maintenance exercises)
* **Home Therapy** (Active rehabilitation / supportive rehabilitation / home environment review)
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| **CLIENT’S PARTICULARS** |
| **Name:** | **Contact No.:** |
| **Date of Birth** (dd/mm/yyyy)**:** | **Gender:** Male / Female |
| **Citizenship:** Singaporean / PR / Others | **NRIC / PASSPORT / FIN / UIN No.:** |
| **NRIC Address:** |
| **Race:** Chinese / Malay / Indian / Others |
| **Language:** English / Mandarin / Malay / Tamil / Dialect(s), please state:  |
| **Marital Status:** Single / Married / Widowed / Divorced |
| **Religion:** |
| **Accommodation Type:** Purchased / Rental / Lodging  Private / HDB If selected HDB, please choose: 1 / 2 / 3 / 4 / 5 / Executive.  |

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| **SOCIAL INFORMATION** |
| **Name of Caregiver / NOK / Contact Person:** | **Relationship to Client:** | **Contact No.** |
| **Reason for Referral**  If selected Others, please state:  |
| Name of Referring Staff: Designation: Department/Organization: Tel/Fax: Email:  |

Please email this form to tsd.referral@thkmc.org.sg, or call 8666 9228.

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| **For Use by THK Only** |
| **Received by:** | **Date Received:** |
| **Appointment Time Given:** Yes / No | **Appointment Date / Time:** |
| **Remarks (if any):** |