AIC Referral Form
(Centre-Based Services)

CGH / SACH / BVH/ Miscellaneous	Fax: 6820 0732	Tel: 6603 6932
NUH / AH / IMH / SLH	Fax: 6820 0729	Tel: 6603 6929
SGH / AMKH / KWSH / Polyclinics	Fax: 6820 0730	Tel: 6603 6930
TTSH / KTPH / RCH	Fax: 6820 0731	Tel: 6603 6931

Official Reg No. _____ *(for AIC input only)*

Day Rehabilitation / Day Care / Dementia Daycare

Please complete all relevant sections and ensure the following documents are attached.

✓ **Medical discharge summary** (for inpatients) ✓ (if available) **PT / OT / Social report / information**

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

SECTION A: SERVICES REQUIRED

❑ Day Rehabilitation
❑ Day Care
❑ Dementia Day Care (please complete additional AIC Dementia Day Care Annexe)

SECTION B: CLIENT'S PARTICULARS (affix patient identification label below if available)

Name : _____

NRIC/Passport/FIN/UIN/No : _____

Date of Birth (dd/mm/yyyy): _____ Age:____

NRIC Address : _____

_____

Postal Code : _____

Telephone : _____

Accommodation : ❑ Private
❑ HDB Room O 1 O 2 O 3 O 4 O 5
O Exec / Others

Housing : ❑ Purchased ❑ Rental ❑ Lodge

Lift-landing : ❑ Yes ❑ No

Residential Address upon discharge (if different from NRIC address) : _____

_____

Current Location of Client : ❑ Home ❑ Others: _____
❑ Hospital - Ward/Bed: _____/_____

Race:
❑ Chinese ❑ Indian ❑ Malay
❑ Eurasian ❑ Others: _____

Gender:
❑ Male ❑ Female

Citizenship / IC colour:
❑ Singaporean / Pink ❑ S'pore PR / Blue
❑ Not available ❑ Others: _____

Marital Status:
❑ Single ❑ Married ❑ Widowed
❑ Separated ❑ Divorced

Language / Dialect Spoken:
❑ English ❑ Mandarin ❑ Malay
❑ Tamil ❑ Cantonese ❑ Hokkien
❑ Teochew ❑ Others: _____

Religion:
❑ Buddhist ❑ Taoist ❑ Islam
❑ Hindu ❑ Christian ❑ Catholic
❑ None ❑ Others: _____

Date of Discharge (planned / actual): _____

SECTION C: SOCIAL INFORMATION

Next-of-Kin: _____ **Relationship to client:** _____

Telephone: _____ **(H)** _____ **(O)** _____ **(Mobile)**

Main Caregiver: _____ **Relationship to client :** _____

Patient is known to other community services: ❑ **No** ❑ **Yes** _____

Patient is known to MSW/ Case Mgr/ Care Coordinator ❑ **No** ❑ **Yes** **Name** _____ **Tel** _____

SECTION D: PREFERENCES

Preferred Centre / Location: _____

Existing client of a Day Rehab/Daycare/Dementia Daycare Centre?

☐ **Yes, specify name of centre at "Preferred Centre/Location"** ☐ **No**

Diet: ❑ No Preference ❑ Yes (pls specify): _____

Duration: ❑ Sessional ❑ Half Day ❑ Full Day ❑ Others (pls specify):_____

Transport required?: ❑ Yes ❑ No

Escort required to bring patient to wait for transport?: ❑ Yes ❑ No

Staircrawl service required? (if patient staying on non-lift landing): ❑ Yes ❑ No

Name of Patient: _____ **NRIC:** _____

Note: SECTION E, F & G are to be completed by Medical Doctor

SECTION E: MEDICAL HISTORY

(If Hospital Medical Discharge Summary is provided, state "SEE ATTACHED" and proceed to SECTION F)

Primary Diagnosis :

Summary of Medical Conditions / Problems (please attach memo if insufficient space)

Summary of Investigations and Management

CXR (date taken _____): ❑ NA ❑ Normal ❑ Abnormal_____

Medications / Dosage / Frequency:

Drug Allergies : ❑ **No** ❑ **Yes :**_____

SECTION F: SCREENING

Does patient currently have any active infectious disease?

❑ No ❑ Yes:_____ **Precaution** ❑Standard ❑Contact ❑Others _____

Are there any other precautions to be taken or conditions that would require closer monitoring?

❑ No ❑ Yes:_____

Please complete the additional questions if applying for Day Rehabilitation Services

Patient requires rehabilitation? ❑ Yes ❑ Trial rehab only ❑ No

Patient is fit to undergo rehabilitation? ❑ Yes ❑ No _____

SECTION G: CURRENT FUNCTIONAL STATUS

Visual Impairment: ❑ No ❑ Yes _____

Hearing Impairment: ❑ No ❑ Yes _____

Mental Status: ❑ Rational ❑ Confused ❑ Unable to respond ❑ Others : _____

Mobility Status: ❑ Bedbound ❑ Wheelchair ❑ Ambulant / Walking

Walking Aid : ❍ N/A ❍ Walking stick / Umbrella ❍ Quadstick ❍ Walking frame ❍ Others

Assistance level required for **wheelchair** or **ambulant/walking**

❍ Independent ❍ Minimal Assist ❍ Moderate Assist ❍ Maximum Assist / Dependent

Activity Tolerance: ❑ Poor (0 to < 15mins) ❑ Fair (15 to 45 mins) ❑ Good (> 45 mins)

Transfers: ❑ Independent ❑ Minimal Assist ❑ Moderate Assist ❑ Maximum Assist / Dependent

Feeding: ❑ Independent ❑ Needs Assistance ❑ Dependent : ❍ Oral ❍ NG tube ❍ PEG

Toileting: ❑ Independent ❑ Needs Assistance ❑ Dependent / Incontinent : ❍ on diapers ❍ urinary catheter

Bowel Management: ❑ Continent ❑ Diapers ❑ Colostomy ❑ ileostomy ❑ Others _____

Respiratory Care: ❑ N/A ❑ Oxygen Therapy ❑ Suction ❑ BIPAP ❑ Trachy care ❑ Others_____

Wound: ❑ N/A ❑ Yes – (site & size) _____

Particulars of Doctor completing Section E, F & G

Name / Signature of Doctor: _____ MCR no.:_____

Hospital / Unit / Designation: _____ Date: _____

SECTION H: REFERRING SOURCE (ie person putting up this referral)

Name : _____ **Designation :** _____

Email : _____ **Contact no:** _____ **Fax:** _____

Request AIC to provide application outcome : ❑ ***No*** ❑ ***Yes*** ***(provide contact details below if different from above)***

Name of Patient: _____ **NRIC:** _____

AIC Dementia Day Care Annexe
(To complete if applying for Dementia Day Care Services)

Please note: Patients referred to Dementia Day Care Centres must be diagnosed to be suffering from dementia by a qualified medical practitioner.

Type of Dementia

❑ Multi-Infarct/Vascular ❑ Alzheimer's Disease ❑ Others: _____

Dementia Followed up

❑ No ❑ Yes (please provide details below)

Dr's name: _____ Designation: _____ Institution: _____

Next TCU date (if applicable): _____ Clinic / Hospital: _____

Cognitive & Behavioural Symptoms (Please tick if present & provide details)

❑ Paranoid & Delusional Ideation: _____

❑ Hallucinations: _____

❑ Day/Night Disturbance: _____

❑ Anxieties & Phobia: _____

Activity Disturbances:	❑ Wandering	❑ Purposeless activity	❑ Inappropriate activity _____
Aggressiveness:	❑ Verbal Outburst	❑ Physical threats &/or violence	❑ Agitation
Affective Disturbance:	❑ Tearfulness	❑ Depressed mood / others _____	

Additional Remarks / Details

Particulars of Person completing Annexe

_____ _____ _____

Name / Signature **Designation / MCR** **Date of Assessment**

Institution / Ward: _____

Telephone / Contact: _____