REFERRAL TO AGED PSYCHIATRY COMMUNITY ASSESSMENT & TREATMENT SERVICE (APCATS) CLINICAL SERVICE

Please ensure that ALL applicable sections of the Referral Form are completed. **FAX to: 6489 -0100**
A formal reply on the outcome of your referral will be sent to the referring person.

Name of Referring Person: ____________________

Referring Clinic/Institution: ____________________

Tel: __________ Fax: __________ Email: __________

Dept: __________ Class of Stay: Subsidised / Non-subsidised

Date of Admission: __________ Discharge: __________

Patient's Details

Name: __________ Address: __________

NRIC: __________ Race: __________ __________

Date of Birth: __________ Dialect Group: __________ Postal code: __________

Age: __________ Sex: M / F Tel: __________ Housing type: __________

Marital status: Married/Single/Widowed/Separated/Divorced Lift landing: Y / N

Occupation: __________ Religion: __________ Language Spoken __________

Patient present location:

- ☐ Home (indicate address if different from above address): __________
- ☐ Institution (pls specify): __________

Key family contact or main caregiver

Name: __________ Relationship: __________

Language spoken __________

Contact number: Home __________ Office: __________ Handphone: __________

Has caregiver consented to referral: Y / N

Diagnosis

Psychiatric Diagnosis: Present __________ First diagnosed in: __________ (year)

Past __________ First diagnosed in: __________ (year)

Reason for referral: ____________________

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Patient is on Psychiatric follow-up currently or in the past? Y / N

If Yes, please elaborate: Name of Psychiatrist ____________________

Hospital/Clinic Name ____________________

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Medical diagnosis: ____________________

Patient is currently receiving home medical/nursing or home help services? Y / N

If Yes, please elaborate: ____________________

Medications

Drug Allergy: ____________________

Current Medications:

1. ____________________ 6. ____________________
2. ____________________ 7. ____________________
3. ____________________ 8. ____________________
4. ____________________ 9. ____________________
5. ____________________ 10. ____________________

Laboratory Investigations, including radiological tests (with dates) (please attach reports if any)

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Current mental status

Appearance:	☐ Good/ Usual	☐ Lethargic	☐ Cachexic	☐ Unkempt
Suicide potential:	☐ High	☐ Moderate	☐ Low	☐ Nil
Aggression potential:	☐ High	☐ Moderate	☐ Low	☐ Nil

Others: ____________________

Current functional status

Mobility: ☐ Independent ☐ Needs Assistance ☐ Wheelchair ☐ Bed-bound

Financial Information

On Public Assistance? Y / N Family needs/wants Means-Testing? Y / N

Social Background (Please include genogram and attach Social Report or Means Test if available)

Signature: ____________________ Date: ____________________

For official use

☐ **Accepted** ☐ **Rejected, reason** ____________________

Assessed by: ____________________ **Date:** ____________________

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