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| APCATS_hi-res_for print | |  | | --- | | **REFERRAL TO AGED PSYCHIATRY**  **COMMUNITY ASSESSMENT & TREATMENT**  **SERVICE (APCATS)**  **CLINICAL SERVICE**  Please ensure that **ALL** applicable sections of the  referral form is completed.  email to: **apcats@imh.com.sg**  A formal reply on the outcome of your referral will  be sent to the referring person. | |

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| **CONSENT TAKING** |
| Patient/caregiver\* consented for referral to APCATS and entry of information into institution’s clinical system.  By agreeing to this referral, patient/caregiver\* consented for IMH APCATS to share any relevant information with their community partners and healthcare institutions involved in their care.  \*Consent to be taken from caregiver only if patient lacks mental capacity  Consent obtained |

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| **REFERRAL SOURCE**  **(Please fill in contact details)**  Name:  Clinic / Institution:  Department: |  | Phone:  Email: |
|  | | |
| **PATIENT DETAILS**  **(Affix sticky label if any)** | | |
| Name:  NRIC:  Race:  Date of Birth: |  | Address:  Sex: **Please select Male/Female** |

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| **KEY FAMILY / CAREGIVER DETAILS** | | |
| Name:  Language spoken: |  | Relationship:  Contact number:  (Home)  (Office)  (HP) |

**CLINICAL INFORMATION**

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| **Psychiatric Diagnosis** |

Present  First diagnosed in:  (Year)

Past First diagnosed in:  (Year)

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| **Current Mobility Status** |

\*Community ambulant  Home-bound  Wheelchair  Bed-bound

If \*Community ambulant, please state additional reason(s) for referral besides patient defaulting clinic attendance, and acceptance of referral will be reviewed on a case by case basis.

Reason(s) for referral:

Is patient on psychiatric follow up current or in the past? **Please select Yes/No**

If yes, please elaborate:

Name of Psychiatrist:

Hospital/Clinic name:

Medical diagnosis:

Is patient currently receiving home medical/nursing or home help services?  **Please select Yes/No**

If yes, please elaborate:

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| **Current Medication** |

|  |  |
| --- | --- |
| 1.  2.  3.  4. | 5.  6.  7.  8. |

Drug Allergy (if any):

Please attach latest discharge summary and laboratory results of patient (if any)

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| **Risk Assessment** |

Suicide potential: **Please select Yes/No**

If yes, please elaborate:

Aggression potential:  **Please select Yes/No**

If yes, please elaborate:

Others:

|  |
| --- |
| **Financial Information** |

Is the patient on public assistance? **Please select Yes/No**

Does the family need/wants Means-Testing (NMTS) to be carried out? **Please select Yes/No\***

\* If prior Means-Testing (NMTS) is done, does family consent to checking of NMTS/HHMT information?

**Please select Yes/No**

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| **Social Background** |

(Please attach genogram and social report or valid Means-Testing results if available)

Signature:  Date: **Please select**

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**FOR OFFICIAL USE**

Accepted  Rejected

Reason for rejection:

Assessed by: Date: **Please select**