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| APCATS_hi-res_for print |

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| **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:  |
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| **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** |

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| 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:

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| **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**