

Doctor's Memo for NTUC Health Day Care and Home Care Services	
Name of Client:	NRIC:
Any Drug Allergy:	<input type="checkbox"/> No <input type="checkbox"/> Yes, please specify:
Any Active Contagious / Infectious Disease:	<input type="checkbox"/> No <input type="checkbox"/> Yes, please specify: Precaution: <input type="checkbox"/> Standard <input type="checkbox"/> Contact <input type="checkbox"/> Others
Past Medical History:	<input type="checkbox"/> No <input type="checkbox"/> Yes, please specify: _____ _____ _____ _____
Current List of Medication:	_____ _____ _____ _____ _____ _____
To complete if applying for dementia day care service (DDC):	
Cognitive & Behavioral Symptoms (Please tick if present & provide details)	
<input type="checkbox"/> Paranoid & Delusional Ideation: _____	
<input type="checkbox"/> Hallucinations: _____	
<input type="checkbox"/> Day/Night Disturbance: _____	
<input type="checkbox"/> Anxieties & Phobia: _____	
Activity Disturbances: <input type="checkbox"/> Wandering <input type="checkbox"/> Purposeless activity <input type="checkbox"/> Inappropriate activity	
Aggressiveness: <input type="checkbox"/> Verbal Outburst <input type="checkbox"/> Physical threats and/or violence <input type="checkbox"/> Agitation	
Affective Disturbance: <input type="checkbox"/> Tearfulness <input type="checkbox"/> Depressed mood / others	

To complete if applying for rehabilitation service:	
<b>Home-based Rehabilitation:</b>	Patient requires rehabilitation ? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Patient is FIT to undergo rehabilitation? <input type="checkbox"/> Yes <input type="checkbox"/> No
	If no: _____
<b>Day Community Rehabilitation:</b>	Patient requires rehabilitation? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Patient is FIT to undergo rehabilitation? <input type="checkbox"/> Yes <input type="checkbox"/> No
	If no: _____
Completed By:	
<b>Name of Doctor, MCR No. &amp; Designation:</b>	<b>Signature:</b>
<b>Institution:</b>	<input type="checkbox"/> Hospital Clinic, please specify which clinic and department: <input type="checkbox"/> Polyclinic, please specify which polyclinic: <input type="checkbox"/> GP / Others, please specify clinic:
<b>Date:</b>	