

This referral can be used commonly to refer your client if more than one of the services is required. Please refer to the boundary listings below to facilitate selection of the appropriate service. The respective service will send an acknowledgement upon receipt of the referral.

NTUC HEALTH REFERRAL FORM

HOME CARE SERVICE (Refer to Annex 1 for details)

- Home Personal Care
- Home Medical
- Home Nursing
- Home Therapy

***Interim Caregiver Services – NTUC Health offers interim caregiver services but referral has to be made through a restructured hospital or community hospital referral team.

Tel: 6715 6715 Email: homecare@ntuhealth.sg

DAY CENTRES FOR SENIORS

DAY REHABILITATION

(Refer to Annex 2 for details)

Centre Locations:

Central:

- 95B Henderson
- Bukit Merah Silat
- Ci Yuan
- May Wong
- Punggol South
- Radin Mas
- Serangoon Central
- Toa Payoh
- Kampung Admiralty

West:

- Jurong Spring
- Boon Lay
- Bukit Batok West
- Jurong Central
- Jurong Central Plaza
- Jurong West
- Marsiling
- Taman Jurong

East:

- Tampines (TBC)
- Chai Chee
- Dakota
- Fengshan
- Geylang East
- Heartbeat@Bedok
- Wisma Geylang Serai
- Pasir Ris

Tel: 6715 6762 Email: seniordaycare@ntuhealth.sg

COMMUNITY BEFRIENDING PROGRAMME

Volunteer befrienders visit seniors in their neighbourhood regularly to enable age in place in their community for as long as possible.

12 constituencies:

Admiralty-Woodlands-Marsiling	Jurong Spring
Ayer Rajah	Lengkok Bahru
Bukit Batok	Nanyang
Dawson	Radin Mas
Henderson	Taman Jurong
Jurong Central	Whampoa

Tel: 6273 2239 Fax: 6273 2356

CLUSTER SUPPORT / CREST @BUKIT MERAH

Provide case management for vulnerable seniors who have little or no family support.

Boundaries served:

Bukit Merah View (except Blk 118)	Jalan Membina
Jalan Bukit Merah	Lengkok Bahru
Tiong Bahru	Telok Blangah Rise
Kim Tian	

Tel: 8612 8302 Email: clustersupport@ntuhealth.sg

CLUSTER SUPPORT / CREST @ TAMAN JURONG

Provide case management for vulnerable seniors who have little or no family support.

Boundaries served:

Boon Lay Corporation	Yung An
Jurong West	Yung Kang
Kan Ching	Yung Loh
Tat Ching	Yung Ping
Tao Ching	Yung Sing

Tel: 9455 2308 Email: clustersupport@ntuhealth.sg

CENTRALIZED CASE MANAGEMENT

Focuses on the planning, provision and coordination of care to meet the needs of the seniors.

Boundaries served:

Bukit Merah (areas not covered by Cluster Support /CREST @ Bukit Merah)

Admissions criteria:

All three criteria must be met:

1. Singapore Citizen or Singaporean PR and aged 60 & above
2. Lives alone / with an incompetent caregiver; and
3. Fulfils at least one of the following:

- Requires assistance in at least one ADL or IADL; issues relating to self-neglect/self-care, medicine compliance, or emotional support;
- Exhibits signs or diagnosed with depression / dementia; or
- Has complex needs requiring case management

(Senior who does not meet the criteria but have extenuating reasons would be considered on a case-by-case basis.)

Tel: 9455 2149 Email: carecomms@ntuhealth.sg

CARE COMMUNITIES @ BUKIT MERAH & TAMAN JURONG

A main focus area to develop proactive and preventative care plans for individuals to improve quality of life.

Boundaries served:

Bukit Merah:

Taman Jurong

116 Bukit Merah View	9A Yuan Ching Rd	111 Ho Ching Rd	177 Yung Sheng Rd	321 Tah Ching Rd
117 Bukit Merah View	9B Yuan Ching Rd	112 Ho Ching Rd	178 Yung Sheng Rd	322 Tah Ching Rd
119 Bukit Merah View	9C Yuan Ching Rd	113 Tao Ching Rd	179 Yung Sheng Rd	323 Tah Ching Rd
120 Bukit Merah View	9D Yuan Ching Rd	114 Ho Ching Rd	180 Yung Sheng Rd	324 Tah Ching Rd
124A Bukit Merah View	9E Yuan Ching Rd	115 Ho Ching Rd	181 Yung Sheng Rd	325 Tah Ching Rd
124B Bukit Merah View	9F Yuan Ching Rd	116 Ho Ching Rd	182 Yung Sheng Rd	326 Tah Ching Rd
125 Bukit Merah View	9G Yuan Ching Rd	117 Ho Ching Rd	183 Yung Sheng Rd	327 Tah Ching Rd
126 Bukit Merah View	9H Yuan Ching Rd	118 Corporation Dr	184 Yung Sheng Rd	328 Tah Ching Rd
128 Bukit Merah View	121 Yuan Ching Rd	119 Ho Ching Rd	361 Yung An Rd	329 Tah Ching Rd
129 Bukit Merah View	122 Yuan Ching Rd	120 Ho Ching Rd	362 Yung An Rd	330 Tah Ching Rd
130 Bukit Merah View	357 Yung An Rd	359 Yung An Rd	363 Yung An Rd	
	358 Yung An Rd	360 Yung An Rd		

Admissions criteria:

1. Singapore Citizen or Singapore PR
2. aged 50 & above

Tel: 9455 2149 Email: carecomms@ntuhealth.sg (Please fill in pg 5 to 8)

CONSENT TAKING (*Compulsory for all services)

I, _____ (name) of _____ (*organisation) have requested for and received consent from the patient/client to refer him/her to you for your services.

***Please indicate "NA" if the referral is for self or for a family member.**

I also agree and undertake to:

- A. notify NTUC Health if he/she withdraws his/her consent to the use and disclosure of his/her Personal Data for this purpose;
- B. assist NTUC Health promptly with all access requests and complaints which may be received from individuals regarding the use of their personal data by the Company;

Personal Data Protection Act

For the purpose of the Personal Data Protection Act ("PDPA"), the Parties consent to provide their personal data to NTUC Health and its affiliates for collection, use and disclosure for the purposes described in our Privacy Policy which can be found on our website ntuhealth.sg/privacy-policy/. Detailed information of what will be shared is described in the Privacy Policy, as well as the rights the Parties are entitled to, including the option to not share their information. You can also request a printed copy of the privacy policy if required.

C. *CLIENT'S PERSONAL PARTICULARS

Name		<input type="checkbox"/> Male	<input type="checkbox"/> Female
NRIC/Passport/FIN/UIN/No.		<input type="checkbox"/> Pink / Singaporean <input type="checkbox"/> Blue / S'pore PR	
Date of Birth (DD/MM/YYYY)		Age:	
NRIC Address			
Postal Code			
Service Address	(if different from NRIC)		
Contact No.	(Mobile)	(Home)	
Weight	Kg		
Marital Status	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed	<input type="checkbox"/> Separated <input type="checkbox"/> Divorced	
Language Spoken	<input type="checkbox"/> English <input type="checkbox"/> Mandarin	<input type="checkbox"/> Malay <input type="checkbox"/> Hindi	

	<input type="checkbox"/> Hokkien <input type="checkbox"/> Teochew <input type="checkbox"/> Cantonese	<input type="checkbox"/> Tamil <input type="checkbox"/> Others:
Religion	<input type="checkbox"/> Buddhist <input type="checkbox"/> Taoist <input type="checkbox"/> Islam	<input type="checkbox"/> Christian <input type="checkbox"/> Catholic <input type="checkbox"/> Others:
Accommodation	<input type="checkbox"/> Private <input type="checkbox"/> HDB: 1/2/3/4/5 (Please circle) <input type="checkbox"/> Exec/Others	
Housing Type	<input type="checkbox"/> Rental <input type="checkbox"/> Lodged	<input type="checkbox"/> Purchased
Lift-landing	<input type="checkbox"/> Yes	<input type="checkbox"/> No

D. *CLIENT'S FUNCTIONAL STATUS

Visual Impairment	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Hearing Impairment	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Mental Status:	<input type="checkbox"/> Rational <input type="checkbox"/> Confused	<input type="checkbox"/> Unable to respond <input type="checkbox"/> Others:
Mobility	<input type="checkbox"/> Walk with / without walking aid <input type="checkbox"/> Others:	<input type="checkbox"/> Wheelchair bound <input type="checkbox"/> Bedridden
Feeding	<input type="checkbox"/> Independent <input type="checkbox"/> Need Assistance	<input type="checkbox"/> Dependent: Oral / NG Tube / PEG (please circle)
Toileting	<input type="checkbox"/> Independent <input type="checkbox"/> Need Assistance	<input type="checkbox"/> Incontinent : Diaper / Urinary Catheter (please circle)
Bowel Management	<input type="checkbox"/> Continent <input type="checkbox"/> Diapers <input type="checkbox"/> Others:	<input type="checkbox"/> Colostomy <input type="checkbox"/> Ileostomy
Respiratory Care	<input type="checkbox"/> NA <input type="checkbox"/> BIPAP <input type="checkbox"/> Suction	<input type="checkbox"/> Tracheostomy Care <input type="checkbox"/> Oxygen Therapy <input type="checkbox"/> Others:

E. *CAREGIVER'S PARTICULARS

Name		Relationship	
Contact No.	(Mobile)	(Home)	
Remarks (please indicate detail, if any)			

F. *NATIONAL MEANS TESTING SYSTEM (NMTS)

Yes: 0%, 30%, 50%, 60%, 75%, 80% (please circle the appropriate subsidy level)

Date of expiry (DD/MM/YYYY): _____

Client is unsure if he/she has applied for NMTS. Client has given consent to check the subsidy level.

No, client would like to apply for NMTS to check on eligibility.

No, client is not eligible for NMTS.

G. *REFERRAL SOURCE (Person putting up this referral)

Name			
Organization & Dept. <i>*Please indicate "NA" if the referral is for self or for a family member.</i>			
Contact No.	(Mobile)	(Office)	
Email.			
Date of Referral			
Signature			

H. *RECOMMENDATION

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I. FOR NTUC HEALTH OFFICIAL USE

Date of Assignment		Date of endorsement	
Name of Staff		Name of endorsing officer	
Name of assigned care coordinator			

ANNEX 1

SERVICES REQUIRED (Please tick as appropriate)

HOME CARE SERVICES
<p><input type="checkbox"/> Home Medical (Refer to Section J):</p> <p><input type="checkbox"/> Follow-up of chronic illness/Prescription of medication</p> <p><input type="checkbox"/> Assessment from FAR (Functional Assessment Report)</p> <p><input type="checkbox"/> Others:</p>
<p><input type="checkbox"/> Home Nursing (Refer to Section J & K):</p> <p><input type="checkbox"/> BP and vital signs monitoring and education</p> <p><input type="checkbox"/> Care Coordination</p> <p><input type="checkbox"/> Changing of nasogastric tube (NGT)</p> <p><input type="checkbox"/> Changing of Urinary Catheters (Female)</p> <p><input type="checkbox"/> Injection</p> <p><input type="checkbox"/> Medication Packing</p> <p><input type="checkbox"/> Phlebotomy Service</p> <p><input type="checkbox"/> Wound and Stoma Care</p> <p><input type="checkbox"/> Disability Assessment</p> <p><input type="checkbox"/> Others: (Please specify) i.e. SMF consumables application (where applicable)</p>
<p><input type="checkbox"/> Home Rehabilitation (Refer to Sections J & L):</p> <p><input type="checkbox"/> Home Environment Review</p> <p><input type="checkbox"/> Physiotherapy</p> <p><input type="checkbox"/> Occupational Therapy</p> <p><input type="checkbox"/> Speech Therapy</p> <p><input type="checkbox"/> Others: (Please specify) i.e. SMF device application (where applicable)</p>
<p><input type="checkbox"/> Home Personal Care Services (Refer to Section J):</p> <p><input type="checkbox"/> Assist in maintenance exercises as prescribed by therapists</p> <p><input type="checkbox"/> Companionship and recreation activities</p> <p><input type="checkbox"/> Light grocery shopping (purchases not more than 3kg within walking distance of client's residential address)</p> <p><input type="checkbox"/> Medical escort without transport service</p> <p><input type="checkbox"/> Mind stimulating activities (for dementia clients)</p> <p><input type="checkbox"/> Personal hygiene (Showering/bed bath)</p> <p><input type="checkbox"/> Respite care for caregivers</p> <p><input type="checkbox"/> Simple meal preparation / Assist in purchasing of food</p> <p><input type="checkbox"/> Others (Please specify): i.e. Light Housekeeping (client living alone, living with aged caregiver etc.)</p>

ANNEX 2

SERVICES REQUIRED (Please tick as appropriate)

DAY CARE SERVICES
<p><input type="checkbox"/> Day Care Services (Refer to Section J):</p> <p><input type="checkbox"/> Maintenance Day Care (MDC)</p> <p><input type="checkbox"/> *Dementia Day Care (DDC)</p> <p><input type="checkbox"/> Transport</p> <p><i>*Clients with a diagnosis of dementia by a Singapore Medical Council-registered medical practitioner.</i></p>
<p>Centre Based Nursing (Refer to Section J):</p> <p><input type="checkbox"/> Post-surgical wound management</p> <p><input type="checkbox"/> Insertion of nasogastric tube (NGT)</p> <p><input type="checkbox"/> Care of PEG tube and dressing</p> <p><input type="checkbox"/> Wound management</p> <p><input type="checkbox"/> Tracheostomy care and dressing</p> <p><input type="checkbox"/> Stoma Care</p> <p><input type="checkbox"/> Care of nephrostomy tube and dressing</p> <p><input type="checkbox"/> Urinary catheter care and change of Urinary Catheters (Female)</p> <p><input type="checkbox"/> Post-procedural medication administration, as ordered by medical personnel</p> <p><input type="checkbox"/> Assistance with bowel elimination (e.g. enema or insertion of suppositories, as ordered by as Singapore Medical Council registered medical practitioner)</p>
<p><input type="checkbox"/> Day Rehabilitation (Refer to Sections J):</p> <p><input type="checkbox"/> Physiotherapy</p> <p><input type="checkbox"/> Occupational Therapy</p> <p><input type="checkbox"/> Speech Therapy</p>

ANNEX 3

J. DOCUMENTS REQUIRED FOR ALL REFERRALS (Please submit all documents within 2 working days from date of referral)

***The memo should include (latest copy with a validity of 1 year or less):**

1. Primary medical diagnoses and other secondary medical conditions, previous surgical and hospitalisation history
2. Drug history including allergies and medication needs

K. ADDITIONAL DOCUMENTS REQUIRED FOR HOME NURSING REFERRALS

1. To attach a wound chart for wound dressing referrals
2. To state brand & size of tube/catheter, and date due for change (for NGT/IDC Referrals)

L. ADDITIONAL DOCUMENTS REQUIRED FOR HOME REHABILITATION REFERRALS

1. Doctor to certify client's need for HOME REHABILITATION (e.g. Inconvenient to go for Day Rehab/Rehab SOC)