SINGHEALTH COMMUNITY NURSING PROGRAMME (NORTH-EAST) REFERRAL FORM

Please send this referral form to: **community.nurse@skh.com.sg**

Respective region point-of-contact:

1. **CNP (Punggol): NC Mohamad Rizal,** **mohd.rizal.mohd.razali@skh.com.sg****, H/P: 8939 7904**
2. **CNP (Sengkang): NC Zhang Jin,** **zhang.jin@skh.com.sg****, H/P: 8428 9735**

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| **Areas** | **Service Boundary (COC)** |
| [ ]  **Sengkang** | **Sengkang West, Fernvale, Anchorvale, Sengkang Town Centre, Compassvale, Rivervale, Lorong Halus North**  |
| [ ]  **Punggol** | **Matilda, Punggol Field, Punggol Town Centre, Waterway East, North Shore, Punggol Canal** |
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| **INCLUSION CRITERIA\*** |
| * Aged ≥ 60 years old
* Has ≥ 3 chronic diseases (e.g. hypertension, hyperlipidemia, diabetes, chronic heart failure, asthma, COPD, stroke)
* Living within the Communities of Care (COC)
* Requires assistance to better manage his/ her chronic diseases

**\* Please contact the community nurse if resident does not meet all of the above criteria but may benefit from this programme.** |
| **EXCLUSION CRITERIA** |
| * Clients with existing home care teams on board
* Clients with ongoing substance abuse and aggressive behavior
* Has only unresolved social issues i.e. no medical or nursing needs (Please consider referral to Community Social Worker/ Family Service Centre)
* New acute symptoms, e.g. chest pain, severe shortness of breath
* Requiring long term clinical procedures e.g. dressing of wound, change of tubes (feeding, catheter, drainage), change of stoma bags, injections etc.
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| **REASONS FOR REFERRAL** |
| [ ] Provide Assessment and Screening (Frailty and Geriatric Level 1 screening)[ ] Health coaching of resident and / or caregiver on chronic disease management[ ] Monitor chronic diseases [ ] Provide medication consolidation and short term medication packing[ ] Others, please specify: **Click or tap here to enter text.** |
| Additional Remarks (if any): **Click or tap here to enter text.** |
| **REFERRING SOURCE** |
| [ ]  CNS [ ]  GSH [ ]  GP : Clinic Name **Click or tap here to enter text.** [ ]  Polyclinic : **Choose an item.**[ ]  Others **Click or tap here to enter text.** |
| Name / Designation: **Click or tap here to enter text.** | Contact: **Click or tap here to enter text.** |
| Referral Date: **Click or tap here to enter text.** | Email Address: **Click or tap here to enter text.** |
| **VERBAL CONSENT TAKEN FOR REFERRAL** |
| [ ]  Client/ Next-of-kin/Caregiver has agreed for referral to SKH Community Nursing Programme, including access to health information necessary for care provision. |

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| **REGISTRATION FORM** |
| **RESIDENT PARTICULARS** |
| Full Name (as in NRIC): **Click or tap here to enter text.** NRIC No: **SXXXXXXXX** |
| Gender: [ ]  Male [ ] Female Date of Birth: **DDMMYYYY** |
| Nationality: [ ]  Singapore Citizen [ ]  Permanent Resident |
| Ethnic Group: [ ]  Chinese [ ]  Malay [ ]  Indian [ ]  Others: **Click or tap here to enter text.** |
| Home Address : **Click or tap here to enter text.** | Postal Code: **XXXXXX** |
| Housing Type: [ ]  HDB 1 to 2-room [ ]  HDB 3-room [ ]  HDB 4-room [ ]  HDB 5-room/Exec [ ]  Others: **\_\_\_\_\_\_** |
| Financial Scheme: [ ]  CHAS: **Choose an item.** [ ]  PA [ ]  MFEC [ ]  Others: **Click or tap here to enter text.** |
| Contact Number (Home) : **Click or tap here to enter text.** | Contact Number (HP):**Click or tap here to enter text.** |
| Language Spoken: [ ]  English [ ]  Mandarin [ ]  Malay [ ]  Tamil [ ]  Others: **Click or tap here to enter text.** |
| **NEXT-OF-KIN/CAREGIVER PARTICULARS (if applicable)** |
| Address (if not the same as Resident):**Click or tap here to enter text.** | Contact Number (Home):**Click or tap here to enter text.** | Contact Number (HP):**Click or tap here to enter text.** |
| Email Address**Click or tap here to enter text.** |
| Preferred Language: [ ]  English [ ]  Mandarin Malay [ ]  Tamil [ ]  Others: **Click or tap here to enter text.** |