REFERRAL FORM

REFERRAL SOURCE		FOR OFFICIAL USE	
Name & Designation		**Receiving Staff**	
Agency/Institution		**Date of Receipt**	|__|__| - |__|__| - |__|__|__|__|
Contact & Email		**Date of First Contact**	|__|__| - |__|__| - |__|__|__|__|
Signature & Date	|__|__| - |__|__| - |__|__|__|__|	**Date of Home Visit**	|__|__| - |__|__| - |__|__|__|__|

SECTION A. CLIENT'S PARTICULARS

Name		**Gender**	☐ Male ☐ Female
Date of Birth	|__|__| - |__|__| - |__|__|__|__|	**Postal Code**	**S** |__|__|__|__|__|__|
Contact	*(home)* *(mobile)*	**Unit No.**	**#** |__|__| - |__|__|__|__|
Ethnicity	☐ Chinese ☐ Malay ☐ Indian ☐ Eurasian ☐ Other:		
Language	☐ English ☐ Mandarin ☐ Malay ☐ Tamil ☐ Other:		

SECTION B. PRESENTING ISSUE(S)

SECTION C. FUNCTIONAL STATUS

Hearing Impairment	☐ Yes ☐ No	**Visual Impairment**	☐ Yes ☐ No	**Ambulant**	☐ Yes ☐ No

SECTION D. SERVICES REQUIRED

Engagement	☐ Befriending	☐ Programmes and Activities	☐ Other:
Elderly Issues	☐ After-life Issues	☐ Advance Care Planning	☐ Digital Assistance
	☐ Grocery Shopping	☐ Home Maintenance	☐ Home Care Services
	☐ Laundry	☐ Lasting Power of Attorney	☐ Meals Delivery
	☐ Personal Hygiene	☐ Other:	
Health Issues	☐ Chronic Condition Monitoring	☐ Medical Escort	☐ Medication Packing
	☐ Home Nursing	☐ Other:	
Financial Issues	☐ Meal Support	☐ Monetary Support	☐ Other:
Caregiver Issues	☐ Navigation of services	☐ Caregiver Stress	☐ Engagement
	☐ Knowledge of/on Resources	☐ Psychoeducation	☐ Respite Care
	☐ Other:		

SECTION E. DECLARATION & CONSENT

☐ I hereby declare the information given above is true and give/do not give* consent to be referred to Sathya Sai Social Service (4S) for the organisation's programmes and services.

☐ I hereby declare the information given above is true and give/do not give* consent to Sathya Sai Social Service (4S) to retain the information and contact me for the organisation's programmes and services.

☐ I allow/do not allow* the information given to Sathya Sai Social Service (4S) to be used for referrals and discussions with other agencies which 4S deem appropriate to assist me.

Name	*(if signed by spokesperson, please indicate name and relationship)*		
Signature/ Date		**Translated By** (if needed)	_____ *(staff)* in _____ *(language)*

For referrals to TAAC, please send in completed form to tembusureferrals@4s.org.sg.
For more enquiries, please call 67421321.