AIC Referral Form
(Community Services)

Name of Patient:_____ **NRIC:**_____--__

Common Fax: 6820 0730

Please call 6603 6931 if you do not receive any acknowledgement within 3 working days

Official Reg No:_____ **Date of fax received:** _____ ____(for *AIC input only)*

Patient / family has consented to this application and to the disclosure of enclosed information to relevant agencies/service providers to facilitate the application ❑ Yes ❑ No

SECTION A: SERVICES REQUIRED (Refer to Service Type Annexe for Descriptions, Page 8)	((Note: Sections B to G are mandatory for all services.

Summary: Additional sections to be completed

SERVICES	H	I	J	K	L
DR	√			√	
DC				√	
DDC		√		√	
HM				√	
HN			√	√	
HR/HBET	√			√	
HER				√	
MOW					√
MET					√
HPC					√

Centre Based Services

❑ **Day Rehabilitation** (Please complete **Section H: Rehab Certification**); specify rehab type:_____

❑ **Day Care**

❑ **Dementia Day Care** (Please complete **Section I: Dementia Information**)

Home Health Care Services

Home Medical Service:

❑ Follow- up of chronic illness/ prescription of medication

❑ Others (specify): _____

Home Nursing Service:

❑ Procedure: (Please complete **Section J: Procedures**)

❑ Health education/ monitoring of BP/ blood glucose

❑ Caregiver Training (specify):_____

❑ Others (specify):_____

Home Therapy Service: (Please complete **Section H: Rehab Certification**)

❑ **Home Rehabilitation** (Intensive)

❑ **Home Based Exercise Training**

❑ **Home Environment Review** (Must be known to subsidized home care provider.)

Home Social Services: (Please complete **Section L: Simplified Eligibility Assessment**)

❑ **Meal-on-Wheels**

❑ **Medical Escort & Transport**

❑ **Home Personal Care:** (Refer to **Service Type Annexe** for following descriptions of sub-services)

❑ Personal Hygiene ❑ Mind Stimulating Activities ❑ Elder-Sitting & Respite

❑ Assistance with other ADLs ❑ Assistance with iADLs

❑ Performing simple maintenance exercises prescribed by Registered Therapist

❑ Assistance with Medication (Excludes medication packing)

SECTION B: REFERRING SOURCE (i.e. person putting up this referral)

Name & Signature: _____

Designation/Institution/Hospital: _____ **Email:** _____

Contact no: _____ **Fax:** _____

SECTION C: CLIENT'S PARTICULARS (affix patient identification label below if available)

Name : _____

NRIC/Passport/FIN/UIN/No : _____

Date of Birth (dd/mm/yyyy) : _____ **Age:** _____

NRIC Address : _____

_____

Residential Address : _____
(If different from NRIC address)

_____

Postal Code : _____

Telephone : _____

Accommodation : ❑ Private ❑ HDB (specify below)
❑1-Rm ❑2-Rm ❑3-Rm ❑4-Rm ❑5-Rm
❑Exec/Others

Housing : ❑ Purchased ❑ Rental ❑ Lodge

Lift-landing : ❑ Yes ❑ No

Race:
❑ Chinese ❑ Indian ❑ Malay
❑ Eurasian ❑ Others: _____

Gender:
❑ Male ❑ Female

Citizenship / IC colour:
❑ Singaporean / Pink ❑ S'pore PR / Blue
❑ Not available ❑ Others: _____

Marital Status:
❑ Single ❑ Married ❑ Widowed
❑ Separated ❑ Divorced

Language / Dialect Spoken:
❑ English ❑ Mandarin ❑ Malay
❑ Tamil ❑ Cantonese ❑ Hokkien
❑ Teochew ❑ Others: _____

Religion:
❑ Buddhist ❑ Taoist ❑ Islam
❑ Hindu ❑ Christian ❑ Catholic
❑ None ❑ Others: _____

Current Location of Client : ❑ Home ❑ Hospital - Ward/Bed: _____/_____

Date of Discharge (planned / actual): _____

SECTION D: SOCIAL INFORMATION

Contact person: _____ **Relationship to patient:** _____ **Tel:** _____

Main Caregiver: _____ **Relationship to patient:** _____

Patient is known to FSC/ Befriender/ Cluster support: ❑ **No** ❑ **Yes (specify)** _____

Patient is known to MSW/ Case Mgr/ Care Coordinator ❑ **No** ❑ **Yes (specify) Name:** _____ **Tel:** _____

Other social details/remarks: _____

SECTION E: PREFERENCES

Preferred Provider (if any): Home Nursing Foundation ❑ **No preference**

Following questions only applicable for Centre Based services

Diet (Day Care/Dementia Day care only): ❑ No Preference ❑ Yes (specify): _____

Transport required? : ❑ Yes ❑ No

Escort required to bring patient to wait for transport? : ❑ Yes ❑ No

Staircrawl service required? (if patient staying on non-lift landing) : ❑ Yes ❑ No

(Transport, Escort & Staircrawl service are subjected to centre availability)

Name of Patient: _____ **NRIC:** _____

SECTION F: MEDICAL HISTORY

If hospital medical discharge summary or doctor memo (doctor's name & MCR no. are stated clearly) is provided, please indicate "see attached" in Section F & G

Primary Diagnosis :

Summary of Medical Conditions / Problems (please attach memo if insufficient space)

Is patient diagnosed as dementia? : ❑ Yes (Proceed to the Type of Dementia) ❑ No ❑ Unsure

Type of Dementia: ❑ Multi-Infarct/Vascular ❑ Alzheimer's Disease ❑ Others: _____

(Please note: Patients referred to Dementia Day Care service must be diagnosed to be suffering from dementia by a SMC registered Medical Practitioner.)

Summary of Investigations and Management

CXR (Date Taken _____): ❑ NA ❑ Normal ❑ Abnormal:_____

Medications / Dosage / Frequency:

Drug Allergies : ❑ **No** ❑ **Yes (Specify):** _____

SECTION G: SCREENING

Does patient currently have any active infectious disease?

❑ No ❑ Yes (specify):_____ **Precaution:** ❑Standard ❑Contact ❑Others _____

Are there any other precautions to be taken or conditions that would require closer monitoring?

❑ No ❑ Yes (specify):_____

PARTICULARS OF DOCTOR OR HEALTHCARE PROFESSIONAL COMPLETING SECTION F & G

Name & signature : _____

Designation :_____

MCR no. (For Doctor) :_____

Institution/hospital :_____

Contact no : _____

Date :_____

Name stamp (if any):

Name of Patient: _____ **NRIC:** _____

SECTION H: REHAB CERTIFICATION

(To complete ONLY if applying for Day Rehabilitation/ Home Rehabilitation Services/ Home-Based Exercise Training.)

1) Patient requires rehabilitation : ❑ Yes (Proceed to question 2) ❑ No

2) Patient fit to undergo rehabilitation : ❑ Yes ❑ No

(Please note: Only a SMC-registered Medical Practitioner or AHPC FULL-registered PT/OT/ST or SNB-registered Advanced Practice Nurse can certify above.)

PARTICULARS OF DOCTOR OR THERAPIST OR APN COMPLETING SECTION H

❑ **SMC registered Medical Practitioner** ○ Refer to particulars of Doctor completing section F & G

❑ **AHPC full-registered PT/OT/ST**

❑ **SNB registered APN**

Name & Signature: _____

MCR No. (For Doctor): _____

Practicing Cert No. (For Therapist): _____

SNB No. (For APN): _____

Name of institution/Hospital: _____

Contact no: _____

Date: _____

Name stamp (if any):

SECTION I: DEMENTIA INFORMATION

(To complete ONLY if applying for Dementia Day Care Service.)

Patient has any dementia follow-up?

❑ No

❑ Yes

Doctor's Name: _____ **Hospital/Institution:** _____ **Next TCU date (if applicable):** _____

Cognitive & Behavioural Symptoms (Please tick if present & provide details)

❑ Paranoid & Delusional Ideation: _____

❑ Hallucinations: _____

❑ Day/Night Disturbance: _____

❑ Anxieties & Phobia: _____

Activity Disturbances: ❑ Wandering ❑ Purposeless activity ❑ Inappropriate activity _____

Aggressiveness: ❑ Verbal Outburst ❑ Physical threats and/or violence ❑ Agitation

Affective Disturbance: ❑ Tearfulness ❑ Depressed mood / others _____

Additional Remarks / Details

Name of Patient: _____ **NRIC:** _____

SECTION J: PROCEDURES (ie wound dressing, change of feeding tube, urinary catheters, stoma, injections etc

(To complete ONLY if applying for Home Nursing Service.)

Feeding tube : ❑ Ryle's tube ❑ Flexiflo/kangaroo ❑ Others, specify_____ Size: _____ Due for change on: _____

Urinary Catheter : ❑ Indwelling ❑ Suprapubic ❑ Clean Intermittent Self Catheterization

Size:_____ Due for change on: _____

Type: ❑ Latex ❑ Silicone elastoma coated ❑ Hydrogel coated ❑ Silicone 100%

Wound : Site: _____ Dressing Type: _____

Freq of Change: _____ Date of last change: _____

Stoma Care : ❑ Tracheostomy Dressing due for change on: _____

❑ PEG Dressing due for change on: _____

❑ Colostomy Dressing due for change on: _____

❑ Ileostomy Dressing due for change on: _____

Injection (IM/ SC) : Type of injection: _____ Dosage: _____ Frequency: _____ Date of last injection:_____

Others: _____

SECTION K: CURRENT FUNCTIONAL STATUS

(SKIP if referral is only for Home Social Services WITHOUT Centre Based &/or Home Health Care Services)

Visual Impairment: ❑ No ❑ Yes _____

Hearing Impairment: ❑ No ❑ Yes _____

Mental Status: ❑ Rational ❑ Confused ❑ Unable to respond ❑ Others: _____

Mobility Status: ❑ Bedbound ❑ Wheelchair ❑ Ambulating (Proceed to Walking Aid)

Walking Aid : ❑ N/A ❑ Walking Stick / Umbrella ❑ Quad Stick ❑ Walking frame ❑ Others:_____

Assistance level required for **wheelchair** or **ambulating**
❑ Independent ❑ Minimal Assist ❑ Moderate Assist ❑ Maximum Assist / Dependent

Activity Tolerance: ❑ Poor (0 to < 15mins) ❑ Fair (15 to 45 mins) ❑ Good (> 45 mins)

Transfers: ❑ Independent ❑ Minimal Assist ❑ Moderate Assist ❑ Maximum Assist / Dependent

Feeding: ❑ Independent ❑ Needs Assistance ❑ Dependent : ❑ Oral ❑ NG tube ❑ PEG

Toileting: ❑ Independent ❑ Needs Assistance ❑ Dependent / Incontinent : ❑ on diapers ❑ urinary catheter

Bowel Management: ❑ Continent ❑ Diapers ❑ Colostomy ❑ ileostomy ❑ Others _____

Respiratory Care: ❑ N/A ❑ Oxygen Therapy ❑ Suction ❑ BIPAP ❑ Trachy care ❑ Others_____

Name of Patient: _____ **NRIC:** _____

SECTION L: SIMPLIFIED ELIGIBILITY ASSESSMENT (PART 1)

(To complete ONLY if applying for Meals On Wheels / Medical Escort & Transport/ Home Personal Care.)

FUNCTIONAL STATUS

1. Does client need any supervision or help to move between locations on the same floor level?
Note : If person is self-sufficient using assistive devices, indicate as No.
0 – No 1 - Yes ☐

2. Does client need any supervision or help to manage personal hygiene?
Includes: Combing hair, brushing teeth, shaving, make-up, washing face or hands.
Excludes: Baths and showers
0 - No 1 - Yes ☐

3. Does client need any supervision or help to bathe or dress and undress below the waist?
Includes: Moving in and out of showers. For dressing/ undressing, includes street clothes, underwear, prostheses, belts, pants, skirts & shoes.
Excludes: Washing of back and hair.
0 - No 1 - Yes ☐

4. Does client have difficulty hearing (with hearing aid normally used)?
0 - No 1 - Yes ☐

5. Does client have difficulty seeing in adequate light (with glasses or with other visual appliance normally used)?
0 - No 1 - Yes ☐

HEALTH CONDITIONS

6. Does client sometimes feel short of breath when performing daily tasks?
Includes: Shortness of breath at rest or during normal daily activities
0 - No 1 - Yes ☐

7. Does client have any conditions that make his/ her health unstable?
Includes: Any disease or condition that causes fluctuating or unstable ADL, cognition, mood, or behavior, such as dementia, heart failure, gout and rheumatoid arthritis.
0 - No 1 - Yes ☐

8. Self-reported health: Ask: "In general, how would you rate your health?"
0 - Excellent/ Good 1 - Fair/ Poor 8 - Could not (would not) respond ☐

9. Self-reported mood: Ask: "In the last 3 days, have you felt sad, depressed or hopeless?"
0 – No 1 - Yes 8 - Could not (would not) respond ☐

COGNITION AND BEHAVIOUR

10. Does someone help client to make decisions about daily tasks?
Includes: When to get up, have meals, clothing, and activities.
0 - No 1 - Yes ☐

11. Ask client to remember 3 unrelated items (e.g. orange, pencil, chair) and let him/ her know you will ask about them again 5 min later. Can client recall after 5 min?
0 - Short-term Memory Ok 1 – Short-term Memory Problem 8 – Unable to Assess ☐

CAREGIVER

12. Does client have a caregiver?
0 - Yes, client stays with caregiver providing 24/7 care or care during the day
1 - Yes, client stays with caregiver who is not at home during the day
2 - No, client stays alone or has no caregiver ☐

13. If client has a caregiver, is the caregiver frail?
0 - No 1 – Yes 8 - NA ☐

14. Caregiver status - Caregiver reports feeling overwhelmed by client's illness
0 - No 1 – Yes 8 - NA ☐

15. If client has a caregiver, does the caregiver have difficulty doing the following for client?
0 - No 1 – Yes 8 - NA

a. Prepare/ buy him meals? ☐
b. Go for appointments with him? ☐
c. Provide personal care for him? ☐

Name of Patient: _____ **NRIC:** _____

SECTION L: SIMPLIFIED ELIGIBILITY ASSESSMENT (PART 2)

(To complete ONLY if applying for Meals On Wheels / Medical Escort & Transport/ Home Personal Care.)

ADDITIONAL ASSESSMENT FOR SERVICES

Please answer Q16 to 18, and 20 for MOW services.
Please answer Q17 to 21, and 25 to 27 for MET services.
Please answer Q21 to 24, and 25 to 27 for HPC services

Functional Status

16. Does client need any supervision or help to prepare or buy his/ her meals? ☐
e.g. planning meals, assembling ingredients, cooking, setting out food and utensils
0 – No 1 - Yes

17. Does client need any supervision or help to manage a full flight of stairs? (12-14 steps) ☐
0 – No 1 - Yes

18. Does client need any supervision or help to travel by public transportation (navigating system, paying fare) or drive him/ herself (including getting out of house, into and out of vehicles)? ☐
0 – No 1 – Yes

19. Does client need any supervision or help to access the common corridor from his or her house? ☐
e.g. navigating stairs or kerb from house to common corridor
0 – No 1 – Yes

20. How does client move around in the community? ☐
0 – Independent 1 – Need quadstick/walking stick
2- Need wheelchair 3 – Total dependence

21. How easily can client transfer him/ herself from bed to chair and back? ☐
0 – Independent 1 – Need set-up help/ supervision/ limited assistance
2 - Need extensive to maximal assistance 3 – Bedbound

22. Can client use the toilet or commode and cleanse him/ herself after toilet use? ☐
0 – Independent 1 – Need set-up help/ supervision/ limited assistance
2 - Need extensive to maximal assistance 3 – Total dependence

23. Can client eat and drink on his/ her own? ☐
Note: Regardless of skill, including tube feeding
0 – Independent 1 – Need set-up help/ supervision/ limited assistance
2 - Need extensive to maximal assistance 3 – Total dependence

24. Does client need any supervision or help for ordinary work around the house? ☐
e.g. doing dishes, dusting, making bed, tidying up, laundry
0 – No 1 – Yes

COGNITION AND BEHAVIOUR

25. Has client displayed any aggressive, socially inappropriate or disruptive behaviour in the last 3 days? ☐
0 - Not present 1 – Present, but not exhibited in last 3 days
2 - Exhibited on 1-2 of last 3 days 3 - Exhibited daily in last 3 days

COMMUNICATION

26. Can client express information content? (includes both verbal & non-verbal expression) ☐
0 - Understood (expresses ideas without difficulty) 1 - Usually/ often understood
2 - Sometimes understood 3 - Rarely or never understood

27. Can client understand information presented to him/ her? (however able; with hearing appliance normally used) ☐
0 - Understands (clear comprehension) 1 - Usually/ often understands
2 – Sometimes understands 3 - Rarely or never understands

28. Any other comments/information (e.g. infectious diseases, client preferences to note etc.)?_____

SERVICE TYPE ANNEXE

(For more details of service type, please refer to Singapore Silver Pages, www.silverpages.sg)

Service Type	Description
Day Rehab (DR) Home Rehabilitation (HR)	Rehabilitation services such as strength, balance and mobility training, activities of daily living ("ADLs") and instrumental ADL ("IADLs") training for seniors who had conditions that affect their mobility or functional abilities e.g. walking, dressing etc. Day rehab is conducted at the rehab centre. Home Rehab is conducted at home, only for home bound patients. Each session may range from 1-1.5 hours dependent on client's need and tolerance.
Home-Based Exercise Training (HBET)	Therapist will design and review maintenance exercise for client and train caregiver on the exercise prescribed.
Day Care (DC)/Dementia Day Care (DDC)	Full day service at centre-based environment, providing care for frail seniors'. It also serves as a support and respite for their family and/ caregivers
Home Medical (HM)	Home medical service caters to frail (home-bound) or bedridden clients who require continuing or long term medical care
Home Nursing (HN)	Home nursing service caters to frail (home-bound) or bedridden clients who need nursing care/procedure(s), such as wound dressing, injections and changing feeding tubes, which can only be provided by a trained nurse.
Meals-On-Wheels (MOW)	Meal delivery service for homebound seniors to continue living in the community despite their frailty and also support working and frail caregivers who is unable to cater to their meals arrangement.
Medical Escort & Transport (MET)	Medical Transport and/ escort service for homebound seniors who encounter difficulties for medical appointments and also support working and frail caregivers who is unable to assist.
Home Personal Care (HPC) ***Providers might not be able to accept stand-alone service like Assistance with Medication/ iADLs (e.g.: grocery shopping and housekeeping)**	Home personal care service caters to frail client who need assistance in personal care tasks e.g. personal hygiene, ADL, iADL etc., which their loved one is unable to cater to such need. Below are the descriptions of sub-service. <u>Personal Hygiene</u> Includes services such as: • Bathing and/or assisted bathing for the Client • Changing of clothes, undergarments, continence aids and any soiled sheets • Brushing of teeth and cleaning of dentures • Toileting and other elimination needs • Cleaning skin around the urinary catheter and draining bags <u>Assistance with other ADLs</u> Includes services such as lifting, transferring and positioning of Client, assisting with oral and/or nasogastric tube feeding. <u>Assistance with iADLs</u> Includes services such as assisting in light housekeeping and laundry, simple errands such as grocery shopping etc. <u>Mind Stimulating Activities</u> Includes services such as playing memory games, mental processing games, spatial orientation block games, Sudoku etc. <u>Elder-Sitting and Respite</u> Includes services such as companionship, and any other recreational and leisure activities within the home setting which is part of the Client's interests. <u>Assistance with Medication</u> Includes services such as medication reminder and assistance with following type of medications: • Oral medications; • Topical medications for stable skin surface; • Intra-aural, nasal and ocular medications; • Dulcolax suppositories • Medicated baths (including Sitz baths) • Metered dose inhalers <u>Performing Simple Maintenance Exercises prescribed by Registered Therapist</u> Performance of simple physical exercises for Client, under direction, prescription and training of a registered therapist