Home Nursing Foundation (HNF) Service Request Form

1. Patient Details			
Name:		NRIC:	
Gender:		Date of birth:	
Race:		Religion:	
Marital status:		Language(s) spoken:	
Citizenship:	Singapore Citizen / Singapore PR		
Contact number:		Housing:	Purchased / Rental / Lodge
Accommodation:	Private / HDB (__ Room) / Others:	Lift landing:	Yes / No
NRIC address:			
Residential Address:			

2. Primary Caregiver Details			
Name:		Contact number:	
Relation to patient:			

3. Details of Person (if not Primary Caregiver) completing this Service Request Form			
Name:		Contact number:	
Relation to patient:			

4. Service(s) Required	
☐ Home Nursing	☐ Home Medical
Specify purpose of service below[1]:	Specify purpose of service below:
☐ Home Therapy	☐ Home Personal Care
Specify purpose of service below:	Specify purpose of service below:

[1]If referral is for wound management: please state type of wound, frequency of change and date of last change. If referral is for NGT or IDC change: please state type of tube, frequency of change and date of last change. If referral is for nursing review: please state type of review required, and frequency of review.

5. Current Functional Status			
Visual impairment:	Yes / No	If "Yes", specify:	
Hearing impairment:	Yes / No	If "Yes", specify:	
Mental status:	Rational / Confused / Unable to respond / Others (specify: _____)		
Mobility status:	Bedbound / Wheelchair / Ambulating (can walk with/without walking aids)		
➔ If "Ambulating":	No walking aids / Walking stick / Quad stick / Walking frame / Others (specify: _____)		
➔ Assistance level required for "Wheelchair" or "Ambulating"	Independent / Minimal assistance / Moderate assistance / Maximum assistance		
Activity tolerance:	Poor (less than 15 minutes) / Fair (15 to 45 minutes) / Good (more than 45 minutes)		
Transfer:	Independent / Minimal assistance / Moderate assistance / Maximum assistance		

Feeding:	Independent / Needs assistance / Dependent: (Oral / NG tube / PEG)
Toileting:	Independent / Needs assistance / Dependent: (Diapers / Urinary catheter)
Bowel management:	Continent / Diapers / Colostomy / Ileostomy / Others (specify: _____)

6. Declaration

☐ I hereby allow HNF to access my / the patient's health records on the National Electronic Health Record (NEHR) System.

☐ I hereby allow HNF to access my / the patient's Means Test result on the National Means Testing System (NMTS).

☐ I hereby agree to withdraw from any other home care and centre-based service providers that I / the patient may currently be under.

Only for patients with no valid medical report or discharge summary within the past year, thus requiring an initial assessment from a HNF doctor:

☐ I hereby acknowledge that my / the patient's eligibility for receiving home care services from HNF is solely based on the HNF doctor's assessment, and that I / the patient may be determined by the HNF doctor to be unsuitable for home care after the doctor's assessment has been done. Regardless of the outcome of the assessment, I acknowledge that I am / the patient is required to pay for the doctor's assessment fee.

7. Endorsement

☐ The above information which I have provided is true to the best of my knowledge, and I will not hold HNF accountable for any mishaps that may arise from any erroneous information that I have provided.

X _____

Name of Signer:

Relationship to Patient:

*Patient **OR** Primary Caregiver (if patient is unable to sign) to sign above.*