

**Referral to Community Resource and Engagement Support Team  
CREST HNF @ Fernvale and Jalan Kayu**

<b>Exclusion Criteria:</b> Persons should not have <u>active</u> substance use. Persons should not be <u>actively</u> suicidal. Persons should not be violent.		
<b>Has the client/ caregiver been informed of referral to CREST</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>SECTION 1: REFERRING PARTY INFORMATION</b>		
Staff Name / Designation / Department / Organization		
Tel	E-Mail	Date
<b>SECTION 2: CLIENT DETAILS</b>		
Name	NRIC	
Address	Date of Birth (dd/mm/yyyy)	
	Age	
Home Contact	Gender	
Mobile	<input type="checkbox"/> Male <input type="checkbox"/> Female	
Citizenship	Race	
<input type="checkbox"/> Singaporean <input type="checkbox"/> Singapore PR <input type="checkbox"/> Others	<input type="checkbox"/> Chinese <input type="checkbox"/> Malay <input type="checkbox"/> Indian <input type="checkbox"/> Eurasian <input type="checkbox"/> Others, please specify: _____	
Marital Status	Religion	
<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Unknown	<input type="checkbox"/> Buddhist <input type="checkbox"/> Christian <input type="checkbox"/> Catholic <input type="checkbox"/> Hindu <input type="checkbox"/> Muslim <input type="checkbox"/> Taoism <input type="checkbox"/> Others: _____	
Preferred Language		
<input type="checkbox"/> English <input type="checkbox"/> Mandarin <input type="checkbox"/> Malay <input type="checkbox"/> Tamil <input type="checkbox"/> Dialect, Specify: _____ (e.g. Hokkien, Cantonese, etc.)		
Employment Status		
<input type="checkbox"/> Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Student <input type="checkbox"/> Retired <input type="checkbox"/> Unknown		
HDB Room Type		
<input type="checkbox"/> 1 room <input type="checkbox"/> 2 room <input type="checkbox"/> 3 room <input type="checkbox"/> 4 room <input type="checkbox"/> 5 room <input type="checkbox"/> Non-HDB / Others, please specify : _____		

Home Ownership

Purchase    Rental    Lodging

Living Arrangement

Family    Spouse    Alone    Others, please specify: \_\_\_\_\_

**SECTION 3: CAREGIVER DETAILS (IF RELEVANT)**

Caregiver Information	Name of Caregiver _____
	Relationship to Client _____      Mobile _____
	Date of Birth / Age _____
	Staying with Client <input type="checkbox"/> Yes <input type="checkbox"/> No

**SECTION 4: CLINICAL INFORMATION OF CLIENTS**

**Mental Health Concern**

- Anxiety
- Caregiver Stress
- Chronic Stress
- Dementia
- Depression
- Obsessive Compulsive Disorder
- Personality Disorders
- Others, please specify: \_\_\_\_\_

**Presenting Issue**

- Employment Issue
- Financial Issue
- Lack of Family Support
- Lack of Independent Living Skills
- Lodging/Housing Issue
- Social Isolation
- Others (Please Specify): \_\_\_\_\_

**Background Information** (any relevant background information about the client, including current living situation, family support, medical history etc.)

**SECTION 5: OTHER RELEVANT INFORMATION**

**Additional information** (may include client's other medical issues, financial means, genogram, social report, hospitalization for psychiatric treatment, history of substance abuse, etc.) Please use additional sheets if necessary. Referral source may also attach a Discharge Summary and Social Report.

**SECTION 6: SAFETY CONCERNS**

Indicate any safety concerns, risk factors, or urgent issues

**SECTION 7: SERVICES REQUIRED**

Required Services

- Caregiver Support
- Counselling Services
- Employment Assistance
- Life Skills Training
- Monitoring and Engagement
- Psychoeducation
- Social Prescribing and Activation