

Home Nursing Foundation (HNF) Service Request Form

1. Patient Details			
Name:		NRIC:	
Gender:	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth: (dd/mm/yyyy)	
Race:		Language(s) Spoken:	
Citizenship:	<input type="checkbox"/> Singapore Citizen <input type="checkbox"/> Permanent Resident <input type="checkbox"/> Foreigner		
Contact No.:	(mobile)	(home)	
Address (as per NRIC):			
Current Residential Address:			
Referred By:	<input type="checkbox"/> Patient / Family (Self-Initiated) <input type="checkbox"/> Other Home Care Providers: _____ (pls state) <input type="checkbox"/> Insurance: _____ (pls state insurer) <input type="checkbox"/> Others: _____ (pls state)		

2. Primary Caregiver Details			
Name:		Contact No.:	
Relation to Patient:			

3. Main Contact Person Details (for appointment follow-up and service contract)			
Name:		Contact No.:	
Relation to Patient:			

4. Service(s) Requested	
<input type="checkbox"/> Home Nursing	<input type="checkbox"/> Home Medical
<p><i>Specify purpose of service below:</i></p> <input type="checkbox"/> Administer medications or injections <ul style="list-style-type: none"> • Name of medication: _____ • Route of administration: _____ <input type="checkbox"/> Monitoring of chronic diseases <ul style="list-style-type: none"> • Type of condition: _____ <input type="checkbox"/> Change feeding tubes & urinary catheters <ul style="list-style-type: none"> • Type of tube: _____ • Frequency of change: _____ • Date of last change: _____ <input type="checkbox"/> Wound and stoma care <ul style="list-style-type: none"> • Type of wound: _____ • Frequency of change: _____ • Date of last change: _____ <input type="checkbox"/> Caregiver training <input type="checkbox"/> Others: _____	<p><i>Specify purpose of service below:</i></p> <input type="checkbox"/> Chronic disease management <ul style="list-style-type: none"> • Type of condition: _____ <input type="checkbox"/> Others: _____
<input type="checkbox"/> Home Therapy	<input type="checkbox"/> Enhanced Home Personal Care
<p><i>Specify purpose of service below:</i></p> <input type="checkbox"/> Physiotherapy (To fill up Annex A) <input type="checkbox"/> Occupational therapy (To fill up Annex A) <input type="checkbox"/> Speech therapy (To fill up Annex A & B)	<p><i>Specify purpose of service below:</i></p> <input type="checkbox"/> Housekeeping <input type="checkbox"/> Personal care & hygiene <input type="checkbox"/> Elder sitting & custodial support <input type="checkbox"/> Monitoring of falls & movement <input type="checkbox"/> Others: _____

5. Current Functional Status (see Glossary of Terms below)	
Visual Impairment:	<input type="checkbox"/> No <input type="checkbox"/> Yes, _____ (pls specify)
Hearing Impairment:	<input type="checkbox"/> No <input type="checkbox"/> Yes, _____ (pls specify)
Mental Status:	<input type="checkbox"/> Unable to respond <input type="checkbox"/> Confused <input type="checkbox"/> Rational <input type="checkbox"/> Others: _____

Mobility:	<input type="checkbox"/> Bedbound <input type="checkbox"/> Wheelchair <input type="checkbox"/> Ambulating (with no aid) <input type="checkbox"/> Ambulating with aid: walking stick/ walking frame/ others (pls specify)
Activity Tolerance:	<input type="checkbox"/> Poor (<15 min) <input type="checkbox"/> Fair (15-45 min) <input type="checkbox"/> Good (>45 min)
Transfer:	<input type="checkbox"/> Maximum assistance <input type="checkbox"/> Moderate assistance <input type="checkbox"/> Minimal assistance <input type="checkbox"/> Independent
Feeding:	<input type="checkbox"/> Needs assistance <input type="checkbox"/> Independent <input type="checkbox"/> Dependent: Oral/ NGT/ PEG (pls specify)
Urinary:	<input type="checkbox"/> Needs assistance <input type="checkbox"/> Independent <input type="checkbox"/> Dependent: Diapers/ Urinary catheter/ Urinal/ Bedpan/ Commode (pls specify)
Bowel Management:	<input type="checkbox"/> Continent <input type="checkbox"/> Diapers <input type="checkbox"/> Colostomy <input type="checkbox"/> Ileostomy <input type="checkbox"/> Others: _____ (pls specify)

6. Declaration	
<input type="checkbox"/>	I hereby allow HNF to access my / the patient's health records on the National Electronic Health Record (NEHR) system.
<input type="checkbox"/>	I hereby allow HNF to access my / the patient's Means Test result on the National Means Testing System (NMTS).
<input type="checkbox"/>	I hereby agree to withdraw from any other home care and centre-based service providers that I / the patient may currently be under.
<p><i>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></p>	
<input type="checkbox"/>	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:

NRIC:

Date: _____

Patient or Primary Caregiver (if patient is unable to sign) to sign/endorse above.

Confidentiality Requirement

To ensure the confidentiality of your information, you are kindly requested to password-protect all submitted documents before returning them.

Please provide the password in a separate email/message from the submitted documents. You may refer to the step-by-step instructions below.

Step-by-Step Instructions Using Adobe Acrobat

Step 1: Open your PDF on Adobe Acrobat.

Step 2: Click File → Protect Using Password.

Step 3: Select “Require a password” to open the document.

Step 4: Enter your chosen password.

Step 5: Click “Apply” and save the file.

Annex A

To be completed for Home Therapy requests.

Reason(s) for referral (tick where appropriate):

- Family/ Patient request: _____
(please input therapy goal)
- Caregiver training/ education on: _____
- Weakness of upper/ lower limbs
- Frequent falls
- Home environment review for safety (refer to OT)
- Wish to move around in community/ gaining independence
- Speech therapy (pls also fill up **Annex B** for Speech Therapy):
 - Frequent choking when feeding
 - To review need for NGT
 - Deterioration in speech/communication

Annex B

To be completed for Speech Therapy requests.

You are advised to complete this form to the best of your knowledge and ability, based on the patient's current status.

Swallowing & Communication Functional Status (see Glossary of Terms below)	
Diet Texture:	<input type="checkbox"/> Liquid <input type="checkbox"/> Pureed <input type="checkbox"/> Minced & moist <input type="checkbox"/> Soft and bite-sized <input type="checkbox"/> Easy to chew <input type="checkbox"/> Regular
Fluid Consistency	<input type="checkbox"/> Thin fluid <input type="checkbox"/> Slightly thick <input type="checkbox"/> Mildly thick <input type="checkbox"/> Moderately thick <input type="checkbox"/> Extremely thick
Speech Ability:	<input type="checkbox"/> Intact <input type="checkbox"/> Mild Impairment <input type="checkbox"/> Moderate impairment <input type="checkbox"/> Severe impairment <input type="checkbox"/> NA
Voice Quality:	<input type="checkbox"/> Intact <input type="checkbox"/> Mild Impairment <input type="checkbox"/> Moderate impairment <input type="checkbox"/> Severe impairment <input type="checkbox"/> NA
Comprehension (Ability to Understand):	<input type="checkbox"/> Intact <input type="checkbox"/> Mild Impairment <input type="checkbox"/> Moderate impairment <input type="checkbox"/> Severe impairment <input type="checkbox"/> NA
Expression (Ability to Express Needs/Wants):	<input type="checkbox"/> Intact <input type="checkbox"/> Mild Impairment <input type="checkbox"/> Moderate impairment <input type="checkbox"/> Severe impairment <input type="checkbox"/> NA
Cognition: <i>*Only for patients with impacted communication (e.g., dementia, psy, TBI)</i>	<input type="checkbox"/> Intact <input type="checkbox"/> Mild Impairment <input type="checkbox"/> Moderate impairment <input type="checkbox"/> Severe impairment <input type="checkbox"/> NA

Glossary of Terms for Section 5: Current Functional Status

S/N	Functional Status	Description	Remarks/ Examples
1	Visual Impairment	Is patient able to see well?	<p>Select “No” for no impairment i.e., patient can see well (both with/without glasses).</p> <p>Select “Yes” for impairment i.e., patient is unable to see well. E.g., patient is blind (indicate percentage of blindness), untreated cataract, glaucoma.</p>
2	Hearing Impairment	Is patient able to hear well?	<p>Select “No” for no impairment i.e., patient can hear well (both with/without hearing aid).</p> <p>Select “Yes” for impairment i.e., patient is unable to hear well.</p>
3	Mental Status	Is patient able to respond to your questions in a rational/ coherent manner?	<p>For patient whose mental status is normal, select Rational.</p> <p>If patient is unable to respond, please indicate reasons (e.g. senior lost ability of speech, post-stroke conditions).</p>
4	Mobility	Is patient able to move around without assistance?	<p>For patient who can walk around without assistance/ difficulties, select “Ambulating (with no aid)”.</p> <p>For patient who can walk around, but require assistance, Select “Ambulating” and indicate type of assistance required (e.g. ambulating with walking stick).</p>
5	Activity Tolerance	How long can patient perform an activity (e.g., sitting up, walking before feeling tired)?	E.g., if patient can only perform an activity for less than 15 minutes, select “Poor”.
6	Transfer	Is patient able to stand up/ sit down without assistance?	Select “Independent” for patient who do not need any assistance.
7	Feeding	Does patient require assistance with feeding?	<p>Select “Independent” for patient who do not need any assistance i.e., able to cut/ scoop their food and feed themselves.</p> <p>Examples of assistance/ dependent:</p> <ul style="list-style-type: none"> Needs assistance: patient needs someone to cut their food, but they can eat it on their own. Dependent (Oral): Patient needs someone to feed them the food.

			<ul style="list-style-type: none"> • Dependent (NG Tube): Patient needs Nasogastric tube for feeding. • Dependent (PEG): Patient needs Percutaneous Endoscopic Gastrostomy tube for feeding.
8	Urinary	Does patient require assistance with urinating?	<p>Select “Independent” for patient who do not need any assistance.</p> <p>Example of assistance: Patient needs someone to bring them to toilet and need help to pull down their pants.</p>
9	Bowel Management	Does patient require assistance with bowel movement?	<p>Select “Continent” for patient who do not need any assistance.</p> <p>For info: Colostomy and Ileostomy are both different types of stomas.</p>
For Annex B			
1	Diet Texture	The type of food the patient can safely eat based on chewing and swallowing ability.	<p>Select “Liquid” if diet consists of only fluids (e.g., soup, milk).</p> <p>Select “Pureed” if diet consists of foods that are smooth, no lumps (e.g., mashed potato).</p> <p>Select “Minced & moist” if diet consists of finely chopped, soft food (e.g., minced meat with gravy).</p> <p>Select “Soft & bite-sized” if diet consists of food in small, soft pieces (e.g., soft rice, tofu).</p> <p>Select “Easy to chew” if diet consists of soft normal food (e.g., noodles).</p> <p>Select “Regular” if there are no restriction to type of food.</p>
2	Fluid Consistency	The thickness of liquids that are safe for swallowing.	<p>Select “Thin” for normal fluids (e.g., water).</p> <p>Select “Slightly thick” if fluid needs to be slightly thicker than water.</p> <p>Select “Mildly thick” if fluid needs to flow slowly (e.g., syrup).</p> <p>Select “Moderately thick” if fluid needs to be thick e.g., honey.</p> <p>Select “Extremely thick” if fluid needs Spoon-thick e.g., pudding.</p>
3	Speech Ability	Ability to clearly produce words and sounds.	<p>Select “Intact” if patient has clear speech, easily understood.</p> <p>Select “Mild” if patient has Slight slurring but still understandable.</p> <p>Select “Moderate” if patient is often unclear; needs repetition.</p> <p>Select “Severe” if Speech mostly not understandable or unable to speak.</p>

4	Voice Quality	Ability to produce voice (volume and strength).	<p>Select "Intact" if patient has strong and normal voice.</p> <p>Select "Mild" if patient has slightly soft or weak voice.</p> <p>Select "Moderate" if patient has noticeably weak or reduced volume.</p> <p>Select "Severe" if patient has Very weak voice or unable to produce voice.</p>
5	Comprehension	Ability to understand spoken or written information.	<p>Select "Intact" if patient understands everything well.</p> <p>Select "Mild" if patient occasionally needs clarification.</p> <p>Select "Moderate" if patient frequently misunderstands.</p> <p>Select "Severe" if patient is unable to understand most communication.</p>
6	Expression	Ability to express needs, thoughts, or wants.	<p>Select "Intact" if patient communicates clearly.</p> <p>Select "Mild" if patient occasional finds difficulty finding the right word.</p> <p>Select "Moderate" if patient has limited vocabulary and needs assistance.</p> <p>Select "Severe" if patient is unable to express needs effectively.</p>
7	Cognition	Thinking skills including memory, attention, and problem-solving (only if affected).	<p>Select "Intact" if patient has normal thinking and memory.</p> <p>Select "Mild" if patient has slight forgetfulness.</p> <p>Select "Moderate" if patient needs prompts or supervision.</p> <p>Select "Severe" if patient has significant confusion from conditions e.g., dementia, brain injury).</p>