Client ID:
(For Brahm Centre Official Use)

REFERRAL FORM

(To submit to info@brahmcentre.com)

Referring Agency Name:	**Date:**
Patient/ family has consented to this referral to Brahm Centre ☐ Yes ☐ No	
Types of Referral(s) ☐ Case Management (CREST/COMIT/Eldersitter) ☐ Counselling ☐ Befriending Service	
Presenting Issues/reason for referral (attach a separate sheet if insufficient space)	

(A) CLIENT'S INFORMATION

Name		**NRIC**	
Address	Singapore ( )	**Citizenship**	☐ Singaporean ☐ PR ☐ Non-citizen
Date of Birth		**Age**	
Contact Details		**Gender**	☐ M ☐ F
Race		**Religion**	
Marital Status	☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Others:		
Living Arrangement	☐ Alone ☐ Children ☐ Spouse Only ☐ Immediate Family ☐ Domestic Helper ☐ Relative ☐ Friend ☐ Others:		
Housing Type	☐ HDB 1 or 2 Rm ☐ HDB 3-room ☐ HDB 4-room ☐ HDB 5-room/ larger ☐ HDB Studio Apartment ☐ Private Flat/House ☐ Others:	**Housing Ownership**	☐ Purchased ☐ Rental – HDB ☐ Rental – Private ☐ Lodging
Language Spoken	☐ English ☐ Mandarin ☐ Malay ☐ Tamil ☐ Hokkien ☐ Teochew ☐ Cantonese ☐ Others:		

(B) MEDICAL HISTORY (To attach discharge summary for Case Management Referral if any)

Medical Condition(s) (Including mental health diagnosis); To list current medications if any	☐ Hypertension ☐ High Cholesterol ☐ Diabetes Mellitus ☐ Dementia ☐ Depression ☐ Schizophrenia ☐ Anxiety Disorder ☐ Others:

(C) COGNITIVE AND BEHAVIOURAL SYMPTOMS (Attach a separate sheet if insufficient space)

Does the client have history of any of the following? (Please describe below if the answer is yes)

Memory issues	☐ No ☐ Yes	Delusions/Hallucinations	☐ No ☐ Yes
Irrelevant/incoherent speech	☐ No ☐ Yes	Suicide risk	☐ No ☐ Yes
Verbal abuse	☐ No ☐ Yes	Aggression/violence	☐ No ☐ Yes

(Describe mood, risk behaviors, suicidal thoughts, history of self-harm, violence if any)

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(D) FAMILY AND SOCIAL HISTORY (Attach a separate sheet if insufficient space)

Describe family background/genogram, dynamics, and support

Contact frequency with family/friends: (relationship) _____
☐ None ☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly ☐ Ad hoc ☐ Others: _____

Describe social interactions, activities, interests, past/current job

Is client known to other community service? ☐ No ☐ Yes (Please specify):

Is client known to *MSW/Case Manager/Care Coordinator? (*delete where not applicable) ☐ No ☐ Yes Name _____
Contact _____
Organization Name _____

Is client on financial assistance? ☐ No ☐ Yes (Please specify): _____

(E) CURRENT FUNCTIONAL STATUS

Recent falls in the past 6 months ☐ No ☐ Yes (Please describe) _____

Visual Impairment ☐ No ☐ Yes (specify R/L/bilateral, any visual aid) _____

Hearing Impairment ☐ No ☐ Yes (specify R/L/bilateral, any hearing aid) _____

Activities of Daily of Living (ADLs) ☐ Independent ☐ Needs assistance ☐ Dependent

Mobility Status ☐ Ambulant ☐ Needs assistance ☐ Dependent

Mobility Aid ☐ N/A ☐ Walking Stick/Quad stick ☐ Walking Frame ☐ Wheelchair ☐ Motorized wheelchair

(F) CAREGIVER (NEXT-OF-KIN) INFORMATION

Name (As in NRIC)			**Contact**	
			Age	
Employment Status	☐ Full-Time ☐ Part-Time ☐ Self-employed	☐ Retired/Homemaker ☐ Unemployed ☐ Unknown	**Relationship with Client**	

Is Caregiver/NOK stated above the main spokesperson for client? ☐ Yes ☐ No

(G) REFERRER INFORMATION

Referrer Name		**Contact No.**	
Designation		**Email**	
Signature			