REFERRAL FORM

Please tick the centre(s) you wish to be referred to:

☐	**SAMH SAY-IT!**	Tel: 9179 4087 / 9179 4085 Email: samhsayit@samhealth.org.sg 59 Ubi Ave 1, Bizlink Centre, #04-12, S(408938)
☐	**Mobile Support Team**	Tel: 8511 2678 Email: samhmobile@samhealth.org.sg Central: Blk 139 Potong Pasir Ave 3, #01-132, S(350139) West: Blk 257 Jurong East St 24, #01-405, S(600257)
☐	**MINDSET Learning Hub**	Tel: 6665 9220 Email: mindsetLH@samhealth.org.sg Blk 257 Jurong East St 24, #01-405, S(600257)
☐	**YouthReach**	Tel: 6593 6424 Email: youthreach@samhealth.org.sg 298 Tiong Bahru Rd, #10-06, Central Plaza, S(168730)
☐	**Oasis Day Centre (via IRMS)**	Tel: 6282 6332 Email: oasis@samhealth.org.sg Blk 139 Potong Pasir Ave 3, #01-132, S(350139)
☐	**Group Homes (via IRMS)**	Tel: 6564 7003 Email: grouphomes@samhealth.org.sg Blk 239 Bukit Batok East Ave 5, #01-165, S(650239)
☐	**Creative SAY!**	Tel: 6362 4845 Email: creativesay@samhealth.org.sg Blk 317 Woodlands St 31, #01-196, S(730317)
☐	**Creative MINDSET Hub**	Tel: 9863 0603 Email: creativemindsethub@samhealth.org.sg 59 Ubi Ave 1, Bizlink Centre, #04-12, S(408938)
☐	**Insight Centre – Counselling Service**	Tel: 6283 1576 Email: counselling@samhealth.org.sg Blk 69 Lorong 4 Toa Payoh, #01-365, S(310069)

DETAILS OF CLIENT		
Client's name:		NRIC no.:
Gender: M / F	Race:	Date of birth:
Address:		(S)
Type of accommodation:		Number of rooms:
Contact no.:	(R)	(H/P)
Email address:		
Languages spoken:		
Educational level:		Occupation:

DETAILS OF FAMILY MEMBER/NEXT OF KIN		
Caregiver's Name:		NRIC no.:
Gender: M / F	Race:	Relationship:
Address:		(S)
Contact no.:	(R)	(H/P)
Email address:		
Languages spoken:		Occupation:

Psychiatrist Report (Where Applicable)

Presenting issues:
Diagnosis/previous mental health history (if any):
Current medication (if any):
Forensic history (if any):
Physical health: History of any significant physical illness? **YES / NO** If yes, specify type and onset, whether stabilized and type of treatment:
Behaviour: **[1]** History of violence? **YES / NO** If yes, specify type and onset, whether stabilized and type of treatment:
Behaviour: [2] Previous suicidal behaviour? **YES / NO** If yes, specify type and onset, whether stabilized and type of treatment:
Purpose of referral & other remarks:

_____ _____

Signature **Date**

Name: Dr _____ **Hospital/Clinic**: _____

Email address: _____ **Contact No.**: _____

SOCIAL REPORT

Strengths of client: _____

_____

_____

_____

_____

_____

Family strengths/challenges: _____

_____

_____

Genogram:

Services utilised from other agencies: _____

_____

_____

Other remarks/important things to note/goals to achieve: _____

_____

_____

Name: _____ **Signature**: _____

Designation: _____ **Organisation:** _____

Telephone (Main): 6- _____ **Telephone (DID)**: 6- _____

Fax no.: _____ **Email Address**: _____

Date of Report: _____

If person to be referred is 18 years old or below, parental consent required.

_____ _____

Signature of Parent/Guardian Date

Name of Parent/Guardian:

***** ***Please attach extra pages if necessary***

For Official Use

Meet/Does not meet initial criteria*

* Please provide reasons: _____

_____

_____

_____

_____

Action taken:

Referred to other SAMH programme: _____

_____

Referred to other VWOs: _____

Others: _____

_____

_____

_____

_____

Name of SAMH Staff/Branch: **Signature:**

_____ **_____**

Date of Report:

_____