REFERRAL FORM

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

☐	**SAMH SAY-IT!**	Tel: 63448451 124 Bedok North Road, #01-133 S(460124)	Email: samhsayit@samhealth.org.sg
☐	**SAMH Mobile Support Team**	Tel: 8511 2678	Email: samhmobile@samhealth.org.sg
☐	**SAMH MINDSET Learning Hub**	Tel: 6665 9220 Blk 257 Jurong East St 24, #01-405, S(600257)	Email: mindsetLH@samhealth.org.sg
☐	**SAMH YouthReach**	Tel: 6593 6424 298 Tiong Bahru Rd, #10-06, Central Plaza, S(168730)	Email: youthreach@samhealth.org.sg
☐	**SAMH C'SAY**	Tel: 6362 4845 Blk 317 Woodlands St 31, #01-196, S(730317)	Email: csay@samhealth.org.sg
☐	**SAMH Creative Hub**	Tel: 9863 0603 / 63448451 124 Bedok North Road, #01-133 S(460124)	Email: creativehub@samhealth.org.sg
☐	**SAMH Insight Centre - Counselling ****	Tel: 6283 1576 Blk 69 Lorong 4 Toa Payoh, #01-365, S(310069)	Email: counselling@samhealth.org.sg

*For referral to SAMH Oasis Day Centre & SAMH Group Homes, pls submit the referral via IRMS
** Referral is optional. Clients can also phone SAMH helpline (1800 283 7019) during office hours to arrange for counselling

DETAILS OF CLIENT		
Client's full name as per NRIC:		NRIC no.:
Client's citizenship:		
Gender: M / F	Race:	Date of birth:
Address:		(S)
Type of accommodation: Rental/Purchased		Private housing/HDB Number of rooms:
Contact no.:	(R)	(H/P)
Email address:		
Languages spoken:		
Educational level:		Occupation:
		Religion

DETAILS OF FAMILY MEMBER/NEXT OF KIN			
Caregiver's **full** name **as per NRIC**:			NRIC no.:
Gender: M / F	Race:	Age:	Relationship:
Address:			(S)
Contact no.:	®		(H/P)
Email address:			
Languages spoken:			Occupation:
Please circle accordingly: Caregiver / Client as main point of contact			

Psychiatrist Report (Where Applicable)

Presenting issues:
Diagnosis/previous mental health history including the year of diagnosis(if any):
Current type of medication, dosage and presenting side effects (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 substance abuse, behavioural or 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, with date joint: _____

_____

_____

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

_____

_____

Name: _____ **Signature**: _____

Designation: _____ **Organisation:** _____

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

Email Address: _____ **Date of Report**: _____

Parental consent required if person to be referred is 18 years old or below.

_____ _____

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:

Accepted: To be admitted on _____

Referred to other SAMH programme: _____

_____

Referred to other VWOs: _____

Others: _____

_____

_____

_____

_____

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

_____ _____

Date of Report:

_____