REFERRAL FORM

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

☐	**Mobile Support Team COMIT (Central)**	Tel: 8511 2678 Email: samhmobile@samhealth.org.sg 1 Maude Road, Level 3, S(200001)
☐	**Mobile Support Team COMIT (West)**	Tel: 8511 2678 Email: samhmobile@samhealth.org.sg Blk 257 Jurong East St 24, #01-405, S(600257)
☐	**Mobile Support Team CREST (T)**	Tel: 8511 2678 Email: samhmobile@samhealth.org.sg 1 Maude Road, Level 3, S(200001)
☐	**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 Blk 298 Tiong Bahru Rd, #10-06, Central Plaza, S(168730)
☐	**Oasis Day Centre**	Tel: 6282 6332 Email: oasis@samhealth.org.sg Blk 139 Potong Pasir Ave 3, #01-132, S(350139)
☐	**Group Homes**	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 Hub**	Tel: 6344 8451 Email: creativehub@samhealth.org.sg 1 Maude Road, Level 3, S(200001)
☐	**SAY-IT!**	Tel: 6344 8451 Email: samhsayit@samhealth.org.sg Blk 124 Bedok North Road, #01-133, S(460124)
☐	**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:			
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:	**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): __________________________________**Telephone (DID)**: _________________

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: ____

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Action taken:
Referred to other SAMH programme: ____

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Referred to other VWOs: ____

Others: ____

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____

Name of SAMH Staff/Branch:

____

Signature:

____

Date of Report:

____