REFERRAL FORM

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

☐	**SAMH SAY-IT! YIT @ East**	Tel: 6344 8451 124 Bedok North Road, #01-133 S(460124)	Email: samhsayit@samhealth.org.sg
☐	**SAMH Mobile Support Team COMIT West**	Tel: 8511 2678	Email: samhmobile@samhealth.org.sg
☐	**SAMH Mobile Support Team COMIT Central**	Tel: 6320 0722	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 Crest-Youth @ North**	Tel: 6362 4845 Blk 317 Woodlands St 31, #01-196, S(730317)	Email: csay@samhealth.org.sg
☐	**SAMH Creative Hub**	Tel: 9863 0603 / 6320 0722 Blk 1 Maude Road, #03-30, S(200001)	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 joined:

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:

_____