



REFERRAL FORM

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

- SAMH SAY-IT! YIT @ East** Tel: 63448451 Email: samhsayit@samhealth.org.sg
 Blk 124 Bedok North Road, #01-133 S(460124)
- SAMH Mobile Support Team COMIT** Tel: 8511 2678 Email: samhmobile@samhealth.org.sg
 Central team: Blk 1 Maude Road, Level 3, Singapore 200001
 West team: Blk 257 Jurong East St 24, #01-405, S(600257)
- SAMH MINDSET Learning Hub** Tel: 6665 9220 Email: mindsetLH@samhealth.org.sg
 Blk 257 Jurong East St 24, #01-405, S(600257)
- SAMH YouthReach** Tel: 8034 8528 (calls only) Email: youthreach@samhealth.org.sg
 298 Tiong Bahru Rd, #10-06, Central Plaza, S(168730)
- SAMH C'SAY CREST – Youth @ North** Tel: 6362 4845 Email: csay@samhealth.org.sg
 Blk 317 Woodlands St 31, #01-196, S(730317)
- SAMH Creative Hub** Tel: 6320 0722 Email: creativehub@samhealth.org.sg
 Blk 1 Maude Road, Level 3, Singapore 200001
- SAMH Insight Centre - Counselling **** Tel: 6283 1576 Email: counselling@samhealth.org.sg
 Blk 69 Lorong 4 Toa Payoh, #01-365, S(310069)

*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.:	(R)	(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? If yes, specify type and onset, whether stabilized and type of treatment:	YES / NO
Behaviour: [1] History of substance abuse, behavioural or violence? If yes, specify type and onset, whether stabilized and type of treatment:	YES / NO
Behaviour: [2] Previous suicidal behaviour? If yes, specify type and onset, whether stabilized and type of treatment:	YES / NO
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 SSAs: _____

Others: _____

Name of SAMH Staff/Branch:

Signature:

Date of Report:
