AWWA HEALTH & SENIOR CARE
CREST REFERRAL FORM

1 REFERRAL SOURCE

Referral From : ☐ **Agency:**_____ ☐ **Clinic/Hospital:**_____ ☐ **Public:** _____

Referral Person/Designation (if any) **:**	**Tel No. / DID :**
Email :	**Date of Referral :**

Consent for Referral: Has Client / Family* consented to this referral and to the disclosure of enclosed information?
☐Yes ☐ No
(*If Client lacks mental capacity to give consent, his/her immediate family member or caregiver is to give consent for this referral on his/her behalf)

2 SERVICE REQUIREMENT

About AWWA CREST [Community Resource, Engagement and Support Team]

AWWA CREST is a community outreach team that serves as a community safety network for people with and/at risk of depression, dementia and other mental health conditions. It also supports their caregivers with resources they need to continue to care for their loved ones at home and in the community.

Services Required:

☐Casework support and follow-up
☐Information & referral services
☐Psychosocial interventions to Client and/or Caregiver
☐Psychoeducation to Client and/or Caregiver
☐Early Identification of Mental Health/Dementia Conditions through screenings

Eligibility Criteria:	**Exclusion Criteria:**
☐Singapore Citizen or Permanent Resident^ ☐18 years old and above ☐Lives within the following areas: ☐Ang Mo Kio ***And must meet at least one of the following criteria:*** ☐May be at-risk / suspected of mental health and/or dementia conditions ☐Diagnosed with mental health and/or dementia and needs community support ☐Caregiver of persons with mental health and/or dementia needing caregiver support	• Personality Disorder, Addiction, Eating Disorders, Neurodevelopmental disorders without other mental health conditions • Individuals with violent tendencies

3 CLIENT'S PARTICULARS

Name:	**NRIC No:**	**Gender:** ☐ M ☐ F
Contact number(s): (Tel / HP)	**Date of Birth:**	**Age:**
Residential Address:		

Housing Type: ☐HDB 1 or 2-Room ☐HDB 3-Room ☐HDB 4-Room ☐HDB 5-Room or larger ☐Condo ☐ Landed Property

Housing Ownership: ☐Purchased ☐Rental ☐Lodging

Living Arrangement:
☐Alone ☐Spouse only ☐Children only
☐Immediate family ☐Relative ☐Friend ☐Others: _____

Spoken Language(s)/Dialect: ☐English ☐ Malay ☐Mandarin ☐ Tamil ☐Hokkien ☐Cantonese ☐ Teochew ☐ Hainanese

Race:	**Religion:**	**Marital Status:**

Education Level: ☐Primary ☐Secondary ☐Tertiary Education ☐No Formal Education

Employment Status: ☐ Employed Full-Time ☐ Employed Part-Time ☐ Self-Employed ☐Retired/Homemaker ☐Unemployed

Occupation (or last known)**:**

Has Domestic Worker: ☐ Yes ☐ No
If Yes, is Domestic Worker the main caregiver? **:** ☐ Yes ☐ No

Brief Social Information/Background: (Please provide social report if available)

4 CAREGIVER / NOK'S PARTICULARS

Name of Caregiver:

NRIC No:

Gender: ☐ M ☐ F

Contact number(s)/Email:

Date of Birth:

Age:

Relationship to Client: ☐Spouse ☐Child ☐Relative ☐Friend ☐Domestic Helper ☐ Others:

Residential Address:
☐ Tick if address is same as Client. Otherwise, please fill in address.

Housing Type: ☐HDB 1 or 2 Room ☐HDB 3-Room ☐HDB 4-Room ☐HDB 5-Room ☐Condo ☐Landed Property

Housing Ownership: ☐Purchased ☐Rental ☐Lodging

Living Arrangements:
☐Alone ☐Spouse only ☒Children only
☐Immediate family ☐Relative ☐Friend ☐Others:_____

Spoken Language(s)/Dialect: ☐English ☐Malay ☐Mandarin ☐ Tamil ☐Hokkien ☐Cantonese ☐Teochew ☐ Hainanese

Race:

Religion:

Marital Status:

Education Level: ☐ Primary ☐ Secondary ☐ Tertiary Education ☐ No Formal Education

Employment Status: ☐ Employed Full-Time ☐ Employed Part-Time ☐ Self-Employed ☐ Retired/Homemaker ☐ Unemployed

Occupation (or last known):

Zarit Score (if available)**:** / 48

Date of Screening:

Describe Signs of Caregiver Stress (if any) **:**
☐ Tick if caregiver would like to be referred to a Caregiver Support Network

5 CLIENT'S INFORMATION

A. Reason(s) for Referral:

B. Brief Medical History, Social History & Functional Status:

For referral from healthcare professionals, please provide following information, latest discharge summary or clinical assessment notes (if available).
For referral from public, please describe and provide information according to your knowledge / understanding.

Mobility Status: ☐Independent ☐Ambulant with walking aid ☐ Ambulant with assistance ☐Wheelchair-bound ☐Bed-bound

Basic Activities of Daily Living (BADLs)

BADL	Independent	Requires Assistance	Dependent
Feeding	☐	☐	☐
Dressing/Grooming	☐	☐	☐
Toileting	☐	☐	☐
Bathing	☐	☐	☐
Transferring	☐	☐	☐
Ambulation	☐	☐	☐

Instrumental Activities of Daily Living (IADLs)

IADL	Independent	Requires Assistance	Dependent
Grocery shopping	☐	☐	☐
House Keeping	☐	☐	☐
Transportation	☐	☐	☐
Meals preparation	☐	☐	☐
Laundry	☐	☐	☐
Use of phone	☐	☐	☐
Managing finances	☐	☐	☐
Managing medications	☐	☐	☐

Screening Test	Date of Screening	Baseline Score	Formally Diagnosed?
EBAS-DEP		/ 8	Depression: ☐ Yes ☐ No **If yes, indicate date of diagnosis:**
AMT		/ 10	Dementia: ☐ Yes ☐ No **If yes, indicate date of diagnosis:**
PHQ-4		/ 4	
PHQ-9		/ 9	Depressive Disorders: ☐ Yes ☐ No **If yes, indicate date of diagnosis:**
GAD-7		/ 7	Anxiety Disorder: ☐ Yes ☐ No **If yes, indicate date of diagnosis:**
WHODAS 2.0		/ 60	
Zarit Burden Scale-12 (Caregiver)		/ 48	

Client's TCUs / Upcoming medical appointment(s)		
Hospital / Clinic: Date / Time:	Hospital / Clinic: Date / Time:	Hospital / Clinic: Date / Time:

C. Known Community Services:

Agency Name / Service Type *(E.g. Family Service Centre, Social Service Office, Day Care Centre, Home-based services, other case management services etc.)*	**Name of Staff**	**Contact No. / Email**