

HANDICAPS WELFARE ASSOCIATION

REHABILITATION CENTRE REFERRAL FORM



Please tick appropriate box for require service & centre

- HWA HQ: 16 Whampoa Drive Singapore 327725 Tel: 62543006 Fax: 62537375
- HWA@Jurong: 1 Jurong West Central 2, # 04-03, Jurong Point Shopping Centre
Singapore 648886 Tel: 67908636 / 67909029 Fax: 67908637

E-mail: hwa@hwa.org.sg Website: www.hwa.org.sg

- Rehabilitation service
- PCS (Personal Care Service)
- Home Therapy

A. PERSONAL DETAILS OF CLIENT

Full Name _____ Race _____
Date of birth ____/____/____ Age _____ Dialect _____
Day Month Year
NRIC No _____ Pink/Blue
Sex: Male Female
Address _____

Tel.: (H) _____ (O) _____
(Hp) _____

B. REFERRAL AGENCY

Name of referring doctor/ therapist
/social worker : _____
Hospital / Clinic / Agency : _____
Department : _____
Address : _____
Tel. : _____
Pager : _____
Fax : _____

C. MEDICAL DETAILS

1. Primary diagnosis

Significant clinical Findings: _____

Significant Investigations : _____

2. Date of onset : _____

3. Other medical problems : _____

4. Past medical history

5. Present complaints

6. Patients functional report (Please attach document if necessary)

a. Mobility status : _____

b. Cognitive : _____

c. Communication : _____

d. ADL : _____

e. Any other significant remarks/assessment _____

7. Rehabilitation potential : Good/Average/Poor

8. Any Other Comments : _____

Signature of referring Person : _____

Date of Referral : _____