REFERRAL FORM
For Outpatient and Home Management Programme

1. CLIENT'S PARTICULARS

Name:_____ **Gender: * Male / Female**

Birth Certificate / NRIC No:_____ **Date of Birth:** _____

Citizenship: Singapore / Permanent Resident / Others:_____

Address:_____

Home No:_____ **Mobile No:**_____

2. FAMILY PARTICULARS

Name of Father:_____

NRIC No:_____ **Date of Birth:** _____

Citizenship: Singapore / Permanent Resident / Others:_____

Occupation_____ **Gross Monthly Income:**_____

Home No:_____ **Mobile No:**_____

Name of Mother:_____

NRIC No:_____ **Date of Birth:** _____

Citizenship: Singapore / Permanent Resident / Others:_____

Occupation_____ **Gross Monthly Income:**_____

Home No:_____ **Mobile No:**_____

Cerebral Palsy Alliance Singapore
Cerebral Palsy Centre
65 Pasir Ris Drive 1 Singapore 519529
Tel: 6585 5600 Fax: 6585 5603 www.cpas.org.sg

(Revised August 2014)

3. FAMILY MEMBERS (Living in the same household)

Name (as in NRIC)	Date of Birth (DD/MM/YY)	Relationship to Applicant	Occupation

DECLARATION

1. **I hereby declare that the information and copies of the documents provided for this application are true and correct to the best of my knowledge.**
2. **I acknowledge that the information of the Application and his/her family members may be shared with NCSS eCMS databases for facilitating financial assistance from CPAS and other organizations. The information of the Applicant and his/her family members will only be shared with authorized persons or agency. However, if the information has any legal implications, it will be made known to the relevant authorities if deemed necessary.**

_____ _____

Signature Of Applicant (if applicable) **Date:**

_____

Name Of Parent/Guardian (As In NRIC):

_____ _____

Signature Of Parent/Guardian **Date:**

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MEDICAL REPORT

Diagnosis:_____

Type of Cerebral Palsy (CP)_____

Other Associated Defects(S):_____

Current medical Problem(s):_____

Birth History: Full Term / Prematurity / Breech / Caesarean Delivery / Others

_____

Neonatal History: Normal /Feeble /Blue at Birth/Convulsions/Jaundice/Others_____

_____

Family History of Cerebral Palsy (if any):_____

Past Illness (if any):_____

_____

Vision:_____ **Hearing:**_____

Drug/Food Allergy (if any):_____

Developmental Milestones:_____

Reason(s) for referral:_____

_____

_____

_____

_____ _____

Name & Designation of Referring Doctor **Signature of Referring Doctor**

_____ _____

Clinic/ Department/Hospital **Date**