

\* Mandatory fields

Referral Source			
<b>Agency: *</b>			
<b>Contact Person: *</b>		<b>Designation: *</b>	
<b>Contact No: *</b>		<b>Email: *</b>	

Client's Particulars			
<b>Name (as in NRIC): *</b>			<b>NRIC: *</b>
<b>DOB: *</b>			<b>Age: *</b>
<b>Nationality: *</b>	<b>Race: *</b>	<b>Gender: *</b> <input type="checkbox"/> Male <input type="checkbox"/> Female	
<b>Living Status: *</b>	<input type="checkbox"/> Alone <input type="checkbox"/> With others. Please specify:		<b>Marital Status:</b>
<b>Residential Address: *</b>			
<b>Ownership: *</b>	<input type="checkbox"/> Own <input type="checkbox"/> Rental <input type="checkbox"/> Others:		
<b>Housing Type:</b>	<input type="checkbox"/> HDB. Please specify: <input type="checkbox"/> Others. Please specify:		
<b>Contact No: *</b>	<b>Home:</b>		<b>Mobile:</b>
<b>Caregiver Contact No:</b>	<b>Name:</b>		<b>Relationship with client:</b>
	<b>Home:</b>		<b>Mobile:</b>
<b>Spoken Language: *</b> (Can tick more than one)	<input type="checkbox"/> English <input type="checkbox"/> Mandarin <input type="checkbox"/> Malay <input type="checkbox"/> Tamil <input type="checkbox"/> Hokkien <input type="checkbox"/> Cantonese <input type="checkbox"/> Others. Please specify:		
<b>Background of client:</b>	<input type="checkbox"/> Mentally well. <input type="checkbox"/> Able to speak coherently and relevantly <input type="checkbox"/> Can use phone (Able to hear and dial out) Any other Background:		

**Privacy and Confidentiality Statement:**

1. This information is collected for the purpose of referral to Changi General Hospital (CGH)'s CareLine Service.
2. I warrant that the information provided on this form is true, complete and accurate.
3. I warrant that I have obtained the consent of the individual in this referral form for the disclosure of their personal information to CGH, and that Client agreed to be bound by all terms and conditions of CareLine.
4. In consideration of CGH agreeing to use the information for CareLine, to the maximum extent permitted under applicable law, I agree that I will, at all times, fully indemnify CGH, its respective partners and service providers and their staff for any claims which may be brought against CGH, its respective partners and service providers and their staff should any warranty I give be false or inaccurate.

<b>Referral Source Staff Signature: *</b>			
<b>Staff Name: *</b>		<b>Date: *</b>	

<b>Official Use</b>			
<b>Referral received on:</b>			
<b>Referral received via:</b>	<input type="checkbox"/> Email <input type="checkbox"/> Fax <input type="checkbox"/> Mail <input type="checkbox"/> Others. Please specify:		
<b>Status:</b>	<input type="checkbox"/> Approved <input type="checkbox"/> Rejected <input type="checkbox"/> Pending		
<b>Remarks:</b> (Reasons for rejection or pending)			
<b>Processed by:</b> (Staff Name and Signature)		<b>Date:</b>	
<b>Approved by:</b> (Staff Name and Signature)		<b>Date:</b>	