



**BEFRIENDING CASE
REFERRAL/REGISTRATION
FORM (Fax: 6273 4521)**

CONFIDENTIAL

NRIC/FIN No* _____ Pink Blue

Name _____

Personal Particulars				
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (DD/MM/YYYY)	Age	Place of Birth	Nationality
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed		Race <input type="checkbox"/> Chinese <input type="checkbox"/> Malay <input type="checkbox"/> Indian <input type="checkbox"/> Others _____		Religion
Family Type/Living Pattern <input type="checkbox"/> Live alone <input type="checkbox"/> With flatmate <input type="checkbox"/> With domestic helper <input type="checkbox"/> With family (children/parent/relative/sibling/spouse*) <input type="checkbox"/> Others _____		Dietary Preference <input type="checkbox"/> Chinese <input type="checkbox"/> Vegetarian <input type="checkbox"/> Halal <input type="checkbox"/> Others _____		
		Spoken Language <input type="checkbox"/> English <input type="checkbox"/> Mandarin <input type="checkbox"/> Malay <input type="checkbox"/> Tamil <input type="checkbox"/> Cantonese <input type="checkbox"/> Hokkien <input type="checkbox"/> Teochew <input type="checkbox"/> Others _____		
Home Ownership/Flat Type <input type="checkbox"/> HDB Rental <input type="checkbox"/> HDB Purchased <input type="checkbox"/> Private		Contact No <input type="checkbox"/> Home <input type="checkbox"/> HP		
No of Rooms <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> Others				
Address 				
Financial Information				
Financial Support	Assistance Type <input type="checkbox"/> PA <input type="checkbox"/> ComCare <input type="checkbox"/> Medifund <input type="checkbox"/> N.A. (Rely on Savings) PA No.: _____ Amt/monthly (\$): _____ ComCare/Medifund Period of Assistance: _____		Other Sources of Support: <i>E.g. family, religious groups, foundations etc.</i> Source/Amt (\$) _____ Source/Amt (\$) _____	
Health Information				
Mobility/Mobility Aid	<input type="checkbox"/> Ambulant <input type="checkbox"/> Semi-ambulant <input type="checkbox"/> Wheelchair-bound <input type="checkbox"/> Bedbound <input type="checkbox"/> Does not use Aids <input type="checkbox"/> Walking Stick/Frame <input type="checkbox"/> Manual/Electric Wheelchair			
Medical Condition(s) <i>E.g. Chronic disease, Dementia, Depression, etc.</i>	List medical condition(s): <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Diabetes <input type="checkbox"/> Heart Disease Any other medical condition(s) or information:			
	Compliance to medication <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Irregular (Reasons: _____)		Known to which hospitals/polyclinic	

Emotional observation during assessment	Did Client appear depressed, display any mood swing/emotional distress E.g. nervousness, anxiety, crying, etc.? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Cognitive observation during assessment	Is the client able to express himself coherently? <input type="checkbox"/> Yes <input type="checkbox"/> No Does the client appear to be forgetful in the course of conversation? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Hearing Ability	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Hard of Hearing <input type="checkbox"/> Deaf	Using Hearing Aid <input type="checkbox"/> Yes <input type="checkbox"/> No	
Eyesight	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> Blind	Cataract (L/R*) Glaucoma (L/R*) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No (Operated/Not Operated*)	Reading Glasses <input type="checkbox"/> Yes <input type="checkbox"/> No
Social Support/Living Conditions			
Family Background			
<input type="checkbox"/> No. of Siblings: ____ (____ Brothers, ____ Sisters) <input type="checkbox"/> No of Children ____ (____ Sons, ____ Daughters) <input type="checkbox"/> Other Next of Kin: _____			
Contact Frequency by Family/Friends	Contact with (relationship): _____ <input type="checkbox"/> None <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly <input type="checkbox"/> Ad hoc <input type="checkbox"/> Others: _____ Contact with (relationship): _____ <input type="checkbox"/> None <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly <input type="checkbox"/> Ad hoc <input type="checkbox"/> Others: _____		
Emergency Contact Person *NOK if possible			
Name:		Relationship:	
Contact No (Home):		(HP):	
Home Living Condition *multiple ticks allowed			
<input type="checkbox"/> Neat <input type="checkbox"/> Cluttered <input type="checkbox"/> Clean <input type="checkbox"/> Dirty <input type="checkbox"/> Bug infested <input type="checkbox"/> Equipped with home safety devices e.g. toilet grab-bars <input type="checkbox"/> Furnishing (Bare/Basic/Well-equipped*)			
Community Support *state agencies or individuals supporting client e.g. Neighbours, Friends, SACs, Other Services, e.g. counselling, home help, rations, etc.			
<input type="checkbox"/> Attends SAC/Religious places of worship _____ (name) _____ (freq.) <input type="checkbox"/> Meals Delivery by _____ <input type="checkbox"/> Housekeeping/Laundry by _____ <input type="checkbox"/> Escort Service by _____ <input type="checkbox"/> Day Care/Counselling by _____ <input type="checkbox"/> Personal Hygiene by _____ <input type="checkbox"/> SSO/FSC/Cluster Support by _____ <input type="checkbox"/> Home Medical/Nursing by _____ <input type="checkbox"/> Others _____			

*Please attach with previous sheet.

Name of Client: _____

NRIC/FIN No. _____

What does Client do to pass time?		Client Interests		
Preferred Day & Time of Home Visit		Other information of client		
Source of Referral				
Referral Date	Referral Person		Referring Organisation	
	Designation			
Contact No		Fax No		Email
Remarks				

FOR OFFICIAL USE			
Date assessed	Assessed by	If Uncontactable, please state visit date	
		<input type="checkbox"/> 1 st Visit Date	<input type="checkbox"/> 2 nd Visit Date
		/ /	/ /
		<input type="checkbox"/> 3 rd Visit Date	
		/ /	
Referral Status		Rejected Reason	
<input type="checkbox"/> Pending <input type="checkbox"/> Approved <input type="checkbox"/> Rejected <input type="checkbox"/> Uncontactable <input type="checkbox"/> Existing Befriender		<input type="checkbox"/> Does not meet criteria <input type="checkbox"/> Rejected Service <input type="checkbox"/> Hospitalised/Institutionalised * <input type="checkbox"/> Passed Away	
Classification			
<input type="checkbox"/> Tier 1 <input type="checkbox"/> Tier 2 <input type="checkbox"/> Tier 3 <input type="checkbox"/> Tier 4			

Declaration

Senior who rejects service during assessment
 I understand the services which have been explained to me but I do not want any befriending service from Lions Befrienders.

Senior who accepts service
 I agree to receive befriending service from Lions Befrienders and the terms of service mentioned below.

Terms of Service *to be explained to Senior

Use of personal data and photographs
 I give consent for LB to release relevant information when required by Social Service Agencies or Sponsors so that I can receive necessary referred services and benefits for activities.

I give consent for LB to use my personal data, photographs and videos taken in the course of receiving services from LB, for publicity or source of Research in LB. However, LB shall request for additional consent to individual media interviews/requests.

Suspension and Termination of Befriending Service
 I understand that LB will suspend befriending service to seniors who have been hospitalised for an extended period of time. In the event senior is institutionalized or upon death, LB will terminate the befriending service.

**For the safety and respect of an abuse-free environment for our staff & volunteers, seniors who display repeated disciplinary behavior, may be suspended if multiple chances & verbal warnings have not been heeded.*

Signature: _____ **Date:** _____