

## APPLICATION FOR ADMISSION TO COMMUNITY HOSPITALS

<input type="checkbox"/> Ang Mo Kio Hosp Fax 64506279	<input type="checkbox"/> St Andrew's CH Fax 65861097	<input type="checkbox"/> St Luke's Hosp Fax 65613625	<input type="checkbox"/> Bright Vision Hosp Fax 68813872	<input type="checkbox"/> KWS Hosp Fax 62991154	<input type="checkbox"/> Ren Ci CH Fax 63556405
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Please ensure that ALL sections of the Application Form are completed. Please tick and fax to only ONE Preferred CH.  
A formal reply on the outcome of your application will be faxed within 1-2 working days.

Referring Hospital \_\_\_\_\_ Ward / Bed \_\_\_\_\_ Tel \_\_\_\_\_ Fax \_\_\_\_\_

Department \_\_\_\_\_ Class of Stay \_\_\_\_\_ Date of Admission \_\_\_\_\_

Type of Ward Preferred → 8 / 10, 6, 5, 4, 2, Single Bedded

**Reason for Referral:**

- Rehab: Please supply PT/OT report**
- Sub-acute**
- Respite: please supply MSW report**

Is the Patient on the Clinical Pathway?

- Yes       No

Please affix patient's identification label here

Name of Pathway \_\_\_\_\_

Date when Patient is ready for transfer

**MEDICAL HISTORY**

Primary Diagnosis

Surgical Operations (if any) \_\_\_\_\_

Past Surgical/Medical History \_\_\_\_\_

History of Present Illness \_\_\_\_\_

Summary of Management \_\_\_\_\_

Physical Examinations \_\_\_\_\_

Relevant Investigations \_\_\_\_\_

(eg ultrasound, X-rays, MRI) \_\_\_\_\_

Any current medical problems that need closer attention or monitoring?  
 No       Yes, please indicate \_\_\_\_\_

**LABORATORY INVESTIGATIONS**

**Hb/TWDC** Latest (Date \_\_\_\_\_) : Hb \_\_\_\_\_ TWDC \_\_\_\_\_ Platelets \_\_\_\_\_  
 On adm (Date \_\_\_\_\_) : Hb \_\_\_\_\_ TWDC \_\_\_\_\_ Platelets \_\_\_\_\_

**U/E/Cr/Sugar** Latest (Date \_\_\_\_\_) : Urea \_\_\_\_\_ Sodium \_\_\_\_\_ Potassium \_\_\_\_\_ Sugar \_\_\_\_\_ Cr \_\_\_\_\_  
 On adm (Date \_\_\_\_\_) : Urea \_\_\_\_\_ Sodium \_\_\_\_\_ Potassium \_\_\_\_\_ Sugar \_\_\_\_\_ Cr \_\_\_\_\_

Name of Patient \_\_\_\_\_ NRIC \_\_\_\_\_ Hosp / Ward / Bed \_\_\_\_\_

**DRUG ALLERGIES**

Current Medications (1) \_\_\_\_\_ (5) \_\_\_\_\_  
(2) \_\_\_\_\_ (6) \_\_\_\_\_  
(3) \_\_\_\_\_ (7) \_\_\_\_\_  
(4) \_\_\_\_\_ (8) \_\_\_\_\_

**DATE OF ONSET OF CURRENT ILLNESS: \_\_\_\_\_**  
**FUNCTIONAL STATUS PRIOR TO ONSET OF CURRENT ILLNESS**

Feeding  Independent  Needed Assistance  N/gastric tube  PEG  
Continenence  Yes  No, patient was on catheter / diaper / \_\_\_\_\_ (others)  
Standing  Could stand independently  Needed Assistance  Unable to stand  
Mobility  Able to ambulate  with aid  without aid  
 Needing assistance from  one person  more than one person  
 Wheelchair bound  Wheelchair-independent  
 Bedbound

**CURRENT FUNCTIONAL STATUS**

Mobility  Independent  Needs Assistance  Wheelchair  Bedbound  
Feeding  Independent  Needs Assistance  N/gastric tube  PEG  
Continenence  Yes  No, patient is on catheter / diaper / \_\_\_\_\_ (others)  
Standing  Can stand independently  Needs Assistance  Unable to stand  
Mental Status  Rational  Confused  Unable to respond  
Obeys Commands  Yes  No  
Pressure Sores/Wounds  Yes \_\_\_\_\_ / \_\_\_\_\_  No  
(Site of sore/wound) (STO date)  
Weight Bearing Status  Full  Partial \_\_\_\_\_  NWB \_\_\_\_\_  
(duration) (Date Allowed to WeightBear)  
Rehab Potential  Good  Fair  Poor

**SOCIAL & POST-DISCHARGE CARE PLAN**

Discharge Destination  Own Home  Voluntary Nursing Home  Private Nursing Home  
Carer Identified  Yes:  Maid  Family: Relationship \_\_\_\_\_  
 No  
Name of Next-of-Kin to Contact \_\_\_\_\_ Relationship \_\_\_\_\_  
Contact Nos. \_\_\_\_\_ (Home) \_\_\_\_\_ (Office)  
\_\_\_\_\_ (Pager) \_\_\_\_\_ (H/phone)  
Is patient known to MSW/Case Mgr?  Yes \_\_\_\_\_ / \_\_\_\_\_  No  
(Name of MSW/CM) (Telephone / Fax)  
If yes, please provide MSW/Case Manager's Report  
Means Test Completed?  Yes \_\_\_\_\_ / \_\_\_\_\_  No  Refused  
(Name/Designation of Person) (Telephone / Fax)  
MOH Subsidy Level  75%  50%  25%  0%  
Method of Payment  Cash  Insurance  Employer / Letter of Guarantee  
 Medisave  Medishield  Medifund  Others  
Is this an Industrial Accident Case?  Yes  No  
Is this a Police Case?  Yes  No

Name of Consultant-in-Charge of Patient \_\_\_\_\_ Department \_\_\_\_\_

Signature/ Name of Referring Doctor \_\_\_\_\_ Designation \_\_\_\_\_ Telephone/Pager \_\_\_\_\_ Date \_\_\_\_\_