

Client Assessment Form

Part 1: Referral Source		
Organisation:		
Address:		S ()
Contact Person:	Designation:	Email:
Office Tel:	Mobile:	Fax:
Signature:		Date of Referral:

Part 2: Particulars of Client		
Name:	NRIC:	Gender: M / F
Address:		S ()
Tel:	Mobile:	
Occupation:	Date of Birth/Age:	
Dialect Spoken: <input type="checkbox"/> Hokkien <input type="checkbox"/> Teochew <input type="checkbox"/> Cantonese <input type="checkbox"/> Hainanese <input type="checkbox"/> Others: _____	Spoken Language(s): <input type="checkbox"/> English <input type="checkbox"/> Mandarin <input type="checkbox"/> Malay <input type="checkbox"/> Tamil <input type="checkbox"/> Others: _____	
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Cohabiting	Citizenship: <input type="checkbox"/> Singaporean <input type="checkbox"/> Others: <input type="checkbox"/> Permanent Resident _____	
Ethnicity: <input type="checkbox"/> Malay <input type="checkbox"/> Eurasian <input type="checkbox"/> Chinese <input type="checkbox"/> Others: _____ <input type="checkbox"/> Indian _____	Education: <input type="checkbox"/> No formal <input type="checkbox"/> ITE/NITEC education <input type="checkbox"/> Pre-U / JC <input type="checkbox"/> Primary <input type="checkbox"/> Tertiary <input type="checkbox"/> Secondary <input type="checkbox"/> Others: _____	Religion: <input type="checkbox"/> Islam <input type="checkbox"/> Roman Catholic <input type="checkbox"/> Hinduism <input type="checkbox"/> No religion <input type="checkbox"/> Buddhism <input type="checkbox"/> Others: <input type="checkbox"/> Christianity _____
Housing Type: <input type="checkbox"/> Rental <input type="checkbox"/> Purchased <input type="checkbox"/> Temporary Accommodation <input type="checkbox"/> Homeless <input type="checkbox"/> Others (please specify): _____ If HDB, _____ -room Lift Landing: <input type="checkbox"/> Yes <input type="checkbox"/> No		

Part 3: Current Source of Financial Support
Client's own income/savings: \$ _____
CPF Minimum Sum Savings: \$ _____ /month

Public Assistance: PA No. _____

Contributions from family members: \$ _____ /month

Other Sources (please specify type & amount): _____

Part 4: Referral For (please tick accordingly)

<p>1. Elderly Healthcare Assistance/ Elderly Issues <input type="checkbox"/> (Case management and Counselling services)</p> <p>2. Caregiver Support Programme <input type="checkbox"/> Caregiver Support Group <input type="checkbox"/> Caregiver Engagement Programme</p> <p>3. Medical Escort <input type="checkbox"/></p> <p>4. Senior Engagement Programme <input type="checkbox"/> (For seniors who are interested to participate in social activities)</p> <p>5. Provisions Assistance <input type="checkbox"/></p> <p>6. Home Personal Care Services <input type="checkbox"/> (For seniors who require assistance with their activities of daily living or require companionship)</p> <p>7. Home Medical Care <input type="checkbox"/> (Home based medical care and procedure)</p>	<p>8. Home Nursing Care <input type="checkbox"/> (Home based nursing care and procedure)</p> <p>9. Home Therapy Service - Rehabilitation <input type="checkbox"/> (For seniors who may require therapy services)</p> <p>10. Elderly Mental Health Programme – ‘The Mind-Able’ <input type="checkbox"/> For seniors who are at risk of developing dementia <input type="checkbox"/> For caregivers looking after seniors with early dementia</p> <p>11. Home Monitoring Service with daily follow up call <input type="checkbox"/> - CCTV - Sensors</p> <p>12. Others <input type="checkbox"/> (specify): _____</p>
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Part 5: Current Living Arrangement

Alone With spouse With family With friend(s) With flatmate(s)

With relatives (specify): _____ Others: _____

Caregiver's Contact _____ (HP) _____ (H/O)

Part 6: Brief Background of the Case (Social Report)

(Please attach separate sheet, if necessary)

Part 7: Family Genogram

Part 8: Other Support		
Name of Agency/Worker	Contact No.	Remark (e.g., relationship/ assistance received)

Part 9: Referral Status	
Has the client been informed of this referral?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Part 10: Assessment and Recommendation (Please attach separate sheet, if necessary)

FOR OFFICIAL USE: Caregiving Welfare Association	
Officer assigned:	
Date assigned:	
Actions to be done:	
Signature:	Date: