

### 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 education <input type="checkbox"/> ITE/NITEC <input type="checkbox"/> Primary <input type="checkbox"/> Pre-U / JC <input type="checkbox"/> Secondary <input type="checkbox"/> Tertiary <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-Active’  <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)




**FOR OFFICIAL USE: Caregiving Welfare Association**

Officer assigned:

Date assigned:

**Actions to be done:**

Signature:

Date: