

## Referral for Adult/Youth COMIT/CREST/CSN/PDS Services

Please complete fields below with information where available, and submit as an attachment on BRIGHT, for reference for AIC to triage accordingly and for Adult/Youth COMIT/CREST/CSN/PDS service providers to follow-up with client.

### Declaration of Consent

☐ Client/ family has consented to this application and to the disclosure of enclosed information to relevant agencies/service providers to facilitate the application

### PATIENT'S INFORMATION

|                                                         |                                                                                                                                                       |                                                            |                                                                                                                |
|---------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------|
| <b>Name*</b>                                            |                                                                                                                                                       |                                                            |                                                                                                                |
| <b>Date of Birth</b>                                    |                                                                                                                                                       | <b>NRIC/FIN*</b><br><i>(if non-SG/PR, please indicate)</i> |                                                                                                                |
| <b>Client's Contact No.*</b>                            |                                                                                                                                                       | <b>Sex</b>                                                 | <input type="checkbox"/> Male<br><input type="checkbox"/> Female<br><input type="checkbox"/> Prefer not to say |
| <b>Address</b>                                          |                                                                                                                                                       | <b>Postal Code*</b>                                        |                                                                                                                |
| <b>Caregiver/<br/>Emergency Contact<br/>Information</b> | Name:<br>Contact No:<br>Email:<br>Relationship to client:                                                                                             |                                                            |                                                                                                                |
| <b>Additional notes</b>                                 | <i>Kindly indicate if client/ caregiver has preferred languages spoken or any other info to note e.g. education, employment status, if applicable</i> |                                                            |                                                                                                                |

\*Mandatory Information required

### REFERRER'S DETAILS

|                                   |                                           |  |
|-----------------------------------|-------------------------------------------|--|
| <b>Referring<br/>Organization</b> | <b>Name of Referrer/<br/>Designation:</b> |  |
|                                   | <b>Ward/ Clinic:</b>                      |  |
|                                   | <b>Organization<br/>Name:</b>             |  |
|                                   | <b>Contact No. and<br/>Email Address:</b> |  |
|                                   | <b>Date of Referral</b>                   |  |

|                                            |                                                                                                                                         |              |                        |
|--------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|--------------|------------------------|
| <b>Assessment(s):</b>                      | Kindly provide the details if any of the following assessments were done for client, and attach any assessment documents, if applicable |              |                        |
|                                            | <b>Assessment Tool*</b>                                                                                                                 | <b>Score</b> | <b>Assessment Date</b> |
|                                            | GAD7                                                                                                                                    |              |                        |
|                                            | PHQ9                                                                                                                                    |              |                        |
|                                            | ZBI                                                                                                                                     |              |                        |
|                                            | K10                                                                                                                                     |              |                        |
|                                            | PSC17                                                                                                                                   |              |                        |
|                                            | CSSRS                                                                                                                                   |              |                        |
|                                            | Others, please specify:                                                                                                                 |              |                        |
| <b>Preferred service provider (if any)</b> | Kindly indicate if this case is meant for YIT / CREST-Youth/ CREST-CSN/ CREST-PDS, else leave blank                                     |              |                        |
| <b>Additional Remarks</b>                  |                                                                                                                                         |              |                        |

**1. Reason(s) for Referral**

Please indicate the type(s) of support recommended for the patient:

- |                                                                                                                        |                                                        |
|------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| <input type="checkbox"/> Psychosocial Intervention (eg. family therapy, relaxation therapy, behavioral management etc) | <input type="checkbox"/> Caregiver support             |
| <input type="checkbox"/> Psychotherapy (eg. CBT)                                                                       | <input type="checkbox"/> Case Management               |
|                                                                                                                        | <input type="checkbox"/> Others (please specify below) |

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**2. Presenting Issues** (Please select all applicable fields)

Clients with high risk, or exclusive presentations of substance use, personality disorder, eating disorder, or high suicidal risk tendencies should be referred to more relevant services to address their needs.

- ☐ Anxious mood
- ☐ Depressed or Low mood
- ☐ Suicide risks and behaviours
- ☐ Coping difficulties
- ☐ Poor Sleep
- ☐ Obsessive or Compulsive Behaviours
- ☐ Abnormal eating habits
- ☐ Trauma
- ☐ Disorientation to time and place
- ☐ Forgetfulness
- ☐ Behavioural symptoms
- ☐ Incoherent speech
- ☐ Talking to self or others
- ☐ Delusional Behaviours

- ☐ Paranoid Behaviours
- ☐ Others, please specify:

\_\_\_\_\_  
\_\_\_\_\_

**Describe the client's presenting concerns, including frequency and severity of symptoms (Include current care/support arrangements, interventions provided, follow-up plans, and details of risk management and safety plans in place. Relevant supporting documents may be attached if required, if applicable):**

\_\_\_\_\_  
\_\_\_\_\_

### 3. Brief History of Client

**Medical Information (Include client's primary diagnosis, any secondary diagnosis, and brief clinical history, if applicable):**

**Medication Prescribed (List names, dosage, frequencies, instructions, and routes of any current medication, if applicable):**