CPAS AT Centre Referral Form

Name of applicant: _____ Date of birth: _____ Male/Female

Medical diagnosis (& medication, if any):

_____

GMFCS: I / II / III / IV / V

Language(s) exposed to: □ English □ Chinese □ Malay □ Tamil □ Other:_____

Stays: □ with family □ in a Home

Type of programme enrolled: □ CPAS School □ EIPIC □ GROW/DAC □ Outpatient □ HMP
□ High support programme
□ Functional programme

Applicant is currently receiving services from: □ None of the following

□ Occupational Therapist Name/Organization: _____
□ Physiotherapist Name/Organization: _____
□ Speech Therapist Name/Organization: _____

Reason for referral

Applicant is having difficulty with (please tick all that are applicable):

□ Activities of daily living (i.e. feeding, dressing and toileting)
□ Communication
□ Mobility
□ Other (specify): _____
□ Computer access
□ Literacy (i.e. reading and writing)
□ Sitting and positioning

Please describe briefly how the applicant's difficulties are affecting his/her abilities to function:

General information

▪ Applicant wears: ▪ hearing aids □ yes □ no ▪ spectacles □ yes □ no

▪ Applicant: □ is non-verbal □ is unintelligible □ is partially intelligible □ is intelligible
□ responds reliably to YES/NO questions □ is inconsistent
▪ indicates YES by (describe): _____
▪ indicates NO by (describe): _____
□ is observed to have behavioural issues □ none observed

▪ Past experience(s) with assistive technology devices: □ yes □ no

If yes, please list briefly: _____

_____

Referred by: _____ (Teacher / Parent / Guardian / OT / PT / ST)

Contact Number: (O/H) _____ (HP) _____ Date of referral: _____

Return form by: _____