CPAS AT Hub Referral Form

Name of client: ____________________ **Class:** ______ **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: ☐ School ☐ EIPIC ☐ GROW/DAC ☐ Outpatient ☐ HMP

Applicant is currently receiving services from:

☐ Occupational Therapist
Name/Organization:
____

☐ Physiotherapist
Name/Organization:
____

☐ Speech Therapist
Name/Organization:
____

☐ Psychologist
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)	Mobility
Communication	Computer access
Vocational skills	Literacy (i.e. reading and writing)
Leisure/Play/ Recreation	Environment control (home appliances , accessing kitchen cabinets, wardrobes etc)

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

☐ Other (specify): _____________________

General information about the client (Tick whichever is applicable)

▪ Client uses: ▪ Hearing aids | Yes | No |

▪ Client uses: ▪Spectacles | Yes | No |

▪ Client is: ☐ is non-verbal ☐ is verbal (please specify below):
☐ is unintelligible
☐ is partially intelligible
☐ is intelligible

▪ Mode of communication:

▪ Client is: ☐ is observed to have behavioural issues ☐ none observed

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

If yes, please list briefly and attach supporting document:

____

____

____

Referred by: ________________________________ (Teacher /AHP)

Contact Number: (O/H) ________________(HP) _____________ Date of referral: ___________

Name & Signature of
referring person:

Name & Signature of
Head of Programme / Department: