# APPLICATION FOR ADMISSION TO COMMUNITY HOSPITALS

| ☐ AMK-THK Hosp<br>Fax 64506279 | ☐ St Andrew's CH<br>Fax 65861097 | ☐ St Luke's Hosp<br>Fax 65613625 | ☐ Bright Vision Hosp<br>Fax 68813872 | |
|---|---|---|---|---|

**Please ensure that ALL sections of the Application Form are completed. Please tick and fax to only ONE Preferred CH.**
**A formal reply on the outcome of your application will be faxed within 1–2 working days.**

Referring Hospital ______________ Ward / Bed _______________ Tel _____________ Fax ____________

Department _____________________ Class of Stay ___________________ Date of Admission ______________

**Type of Ward Preferred** → 8 / 10, 6, 5, 4, 2, Single Bedded

Please affix patient's identification label here

**Reason for Referral:**

- ☐ **Rehab: Please supply PT/OT report**
- ☐ **Sub-acute**
- ☐ **Respite: please supply MSW report**

**Is the Patient on the Clinical Pathway?**

☐ Yes ☐ No

Name of Pathway ____________________

**Date when Patient is ready for transfer** ____________________

## MEDICAL HISTORY

Primary Diagnosis ____________________

Surgical Operations (if any) ____________________

Past Surgical/Medical History ____________________

History of Present Illness ____________________

Summary of Management ____________________

Physical Examinations ____________________

Relevant Investigations
(eg ultrasound, X-rays, MRI) ____________________

**Any current medical problems that need closer attention or monitoring?**

☐ No ☐ Yes, please indicate ____________________________________________________________

## LABORATORY INVESTIGATIONS

**Hb/TWDC** **Latest** (Date ________) : Hb _________ TWDC ______________ Platelets _______
On adm (Date _______) : Hb __________ TWDC _____________ Platelets _______

**U/E/Cr/Sugar** **Latest** (Date ________) : Urea _____ Sodium ______ Potassium ______ Sugar ______ Cr _____
On adm (Date _______): Urea _____ Sodium ______ Potassium ______ Sugar ______ Cr _____

Name of Patient ________________________ NRIC _____________ Hosp / Ward / Bed_____________

**DRUG ALLERGIES** ____________________________________________________________

Current Medications (1) ______________________________ (5) __________________________________
(2) ______________________________ (6) __________________________________
(3) ______________________________ (7) __________________________________
(4) ______________________________ (8) __________________________________

## DATE OF ONSET OF CURRENT ILLNESS: _______________

## FUNCTIONAL STATUS PRIOR TO ONSET OF CURRENT ILLNESS

| | | | | |
|---|---|---|---|---|
| Feeding | ☐ Independent | ☐ Needed Assistance | ☐ N/gastric tube | ☐ PEG |
| Continence | ☐ Yes | ☐ No, patient was on catheter / diaper /_____________ (others) | | |
| Standing | ☐ Could stand independently | ☐ Needed Assistance | ☐ Unable to stand | |
| Mobility | ☐ Able to ambulate | ☐ with aid | ☐ without aid | |
| | ☐ Needing assistance from | ☐ one person | ☐ more than one person | |
| | ☐ Wheelchair bound | ☐ Wheelchair-independent | | |
| | ☐ Bedbound | | | |

## CURRENT FUNCTIONAL STATUS

| | | | | |
|---|---|---|---|---|
| Mobility | ☐ Independent | ☐ Needs Assistance | ☐ Wheelchair | ☐ Bedbound |
| Feeding | ☐ Independent | ☐ Needs Assistance | ☐ N/gastric tube | ☐ PEG |
| Continence | ☐ Yes | ☐ No, patient is on catheter / diaper / _____________ (others) | | |
| Standing | ☐ Can stand independently | ☐ Needs Assistance | ☐ Unable to stand | |
| Mental Status | ☐ Rational | ☐ Confused | ☐ Unable to respond | |
| Obeys Commands | ☐ Yes | ☐ No | | |
| Pressure Sores/Wounds | ☐ Yes ____________________ (Site of sore/wound) / __________ (STO date) | | | ☐ No |
| Weight Bearing Status | ☐ Full | ☐ Partial _________ (duration) | ☐ NWB ____________________ (Date Allowed to WeightBear) | |
| Rehab Potential | ☐ Good | ☐ Fair | ☐ Poor | |

## SOCIAL & POST-DISCHARGE CARE PLAN

Discharge Destination ☐ Own Home ☐ Voluntary Nursing Home ☐ Private Nursing Home

Carer Identified ☐ Yes: ☐ Maid ☐ Family: Relationship _________________
☐ No

Name of Next-of-Kin to Contact ______________________________ Relationship ___________________

Contact Nos _____________________ (Home) ________________________ (Office)
_____________________ (Pager) ________________________ (H/phone)

Is patient known to MSW/Case Mgr? ☐ Yes ________________________ (Name of MSW/CM) / ___________ (Telephone / Fax) ☐ No

If yes, please provide MSW/Case Manager's Report

Means Test Completed? ☐ Yes _______________________ (Name/Designation of Person ) / ____________ (Telephone / Fax) ☐ No ☐ Refused

MOH Subsidy Level ☐ 75% ☐ 50% ☐ 25% ☐ 0%

Method of Payment ☐ Cash ☐ Insurance ☐ Employer / Letter of Guarantee
☐ Medisave ☐ Medishield ☐ Medifund ☐ Others

Is this an Industrial Accident Case? ☐ Yes ☐ No

Is this a Police Case? ☐ Yes ☐ No

Name of Consultant-in-Charge of Patient ____________________________ Department _____________________

___________________________________ _________________ ___________________ _____________

Signature/ Name of Referring Doctor | Designation | Telephone/Pager | Date