sata CommHealth

Mobile CHC Referral Form

Patient's name, NRIC & DOB:		Patient's Contact No.:	
Clinic Name:		Clinic Contact No.	

HEALTH INFORMATION			
Height (cm):	Weight (kg):	Body Mass Index (BMI):	Blood Pressure (mmHg):

SECTION A: CHRONIC CONDITIONS (Please tick where applicable)		
CARDIOVASCULAR ☐ Hypertension ☐ Lipid Disorders	**ENDOCRINE** ☐ Diabetes ☐ Pre-diabetes	☐ **OTHERS** *(Please specify)*:

SECTION B: PURPOSE OF REFERRAL (Please tick where applicable)		Part II: Nurse Counselling (NC)	
Part I: Ancillary Services			
Packages	**Single Services**	**Lifestyle Counselling**	**Skills Specific Counselling**
☐ Package 1 [DRP + DFS + NC] ☐ Package 2 [DRP + DFS] ☐ Package 3 [DRP + NC] ☐ Package 4 [DFS + NC] *For NC please fill up Part II*	☐ DFS ☐ DRP ☐ NC *(Please fill up Part II)*	☐ Diet ☐ Exercise ☐ Medication Adherence	☐ Home Blood Glucose Monitoring ☐ Home BP Monitoring
		No. of Sessions Required: ☐1 ☐ 2 ☐ 3 ☐ 4	

SECTION C: ADDITIONAL INFORMATION	
GP CONCERNS	
PATIENT / FAMILY / CAREGIVER CONCERNS	
LEARNING BARRIERS	☐ Cognitive impairment ☐ Vision ☐ Hearing ☐ Language ☐ N/A ☐ Others *(Please specify)*:

Doctor's Name & MCR No.:

Date: