**PCN Referral to AIC CareinMind**

For referral of clients with mental health needs

Please email this form to: [careinmind@aic.sg](mailto:careinmind@aic.sg)

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| **Client & Next of Kin Particulars** |
| **Client**   |  |  | | --- | --- | | Name: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | NRIC: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender  Male  Female | | Age: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | Address: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | Contact No | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Next GP Appt Date/Time\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | Languages Spoken |  English  Chinese  Malay  Tamil  Others |   **Did client give consent for this referral?** Yes / No (Please Circle)    **Next of Kin**   |  |  | | --- | --- | | Name: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| **Client’s Medical Background** |
| **Psychiatric Diagnosis/History**  **Medical Conditions (if any)**   Diabetes  Hypertension  Hyperlipidaemia  Others\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Current Medication**  **Presenting issues / Reason for referral**  **Family background and social support (if any)** |
| **Referring Clinic** |
| |  |  |  |  | | --- | --- | --- | --- | | **Name of Doctor:** | :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **PCN** | :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | **Clinic Name** | :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Contact** | :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | **Date:** | :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |