Home Nursing Foundation (HNF) Service Request Form

1. Patient Details			
Name:		NRIC:	
Gender:		Date of birth:	
Race:		Religion:	
Marital status:		Language(s) spoken:	
Citizenship:	Singaporean		
Contact number:		Housing:	Lodge
Accommodation:	Private	Lift landing:	NA
Address as per NRIC:			
Residential Address:			

2. Primary Caregiver details			
Name:		Contact number:	
Relation to patient:			

3. Details of Person (if not Primary Caregiver) completing this Service Request Form			
Name:		Contact number:	
Relation to patient:			

4. Service(s) Required	
☐ Home Nursing	☐ Home Medical
Specify purpose of service below[1]:	Specify purpose of service below:
☐ Home Therapy – Pls also fill up Annex A	☐ Home Personal Care
Specify purpose of service below:	Specify purpose of service below:

[1]If referral is for wound management: please state type of wound, frequency of change and date of last change. If referral is for NGT or IDC change: please state type of tube, frequency of change and date of last change. If referral is for nursing review: please state type of review required, and frequency of review.

5. Current Functional Status			
Visual impairment:	No	If "Yes", specify:	
Hearing impairment:	No	If "Yes", specify:	
Mental Status:	Others		
Mobility:	Ambulating (with other form of walkin		
Activity tolerance:	Poor (less than 15 mGood (more than 45 min		
Transfer:	Maximum Assistance		
Feeding:	Dependent: (PEG)		
Urinary:	Dependent (Commode)		
Bowel management:	Ileostomy If choose "Others", specify: _____		

6. Declaration

☐ I hereby allow HNF to access my / the patient's health records on the National Electronic Health Record (NEHR) system.

☐ I hereby allow HNF to access my / the patient's Means Test result on the National Means Testing System (NMTS).

☐ I hereby agree to withdraw from any other home care and centre-based service providers that I / the patient may currently be under.

Only for patients with no valid medical report or discharge summary within the past year, thus requiring an initial assessment from a HNF doctor.

☐ I hereby acknowledge that my / the patient's eligibility for receiving home care services from HNF is solely based on the HNF doctor's assessment, and that I / the patient may be determined by the HNF doctor to be unsuitable for home care after the doctor's assessment has been done. Regardless of the outcome of the assessment, I acknowledge that I am / the patient is required to pay for the doctor's assessment fee.

7. Endorsement

☐ The above information which I have provided is true to the best of my knowledge, and I will not hold HNF accountable for any mishaps that may arise from any erroneous information that I have provided.

X _____

Name of Signer:
Relationship to Patient:
NRIC if not patient:

Date: _____

Patient OR Primary Caregiver (if patient is unable to sign) to sign above.

Annex A

For Home Therapy only.

Reason for referral (tick as appropriate) for consideration:

- ☐ Family/patient request for: _____ (please input goal)
- ☐ Achieve functional status: _____
- ☐ Caregiver training/ education: _____
- ☐ Weakness of upper/ lower limbs
- ☐ Endurance training
- ☐ Frequent falls
- ☐ Swallowing
- ☐ Wish to move around in community/ gaining independence
- ☐ Speech Therapy:
  - ☐ Swallowing
  - ☐ Speech

Glossary of Terms for Section 5: Current Functional Status

	Functional Status	Description	Remarks/Examples
1	Visual Impairment	Is senior able to see well?	Select "No" for no impairment, i.e. senior can see well (both with/without glasses). Select "Yes" for impairment, i.e. senior is unable to see well. E.g. senior is blind (indicate percentage of blindness), untreated cataract, glaucoma.
2	Hearing Impairment	Is senior able to hear well?	Select "No" for no impairment, i.e. senior can hear well (both with/without hearing aid). Select "Yes" for impairment, i.e. senior is unable to hear well.
3	Mental Status	Is senior able to respond to your questions in a rational/coherent manner?	For seniors whose mental status is normal, select Rational. If senior is unable to respond, please indicate reasons (e.g. senior lost ability of speech, post-stroke conditions).
4	Mobility	Is senior able to move around without assistance? Select the option that best describes how senior moves around.	For seniors who can walk around without assistance/difficulties, select Ambulating (NA). For seniors who can walk around, but require assistance, select Ambulating, and indicate type of assistance required (e.g. ambulating with walking stick).
5	Activity Tolerance	How long can senior perform an activity (e.g. sitting up, walking) before feeling tired?	E.g. if senior can only perform an activity for less than 15 minutes, select Poor.

6	Transfer	Is senior able to stand up/sit down without assistance?	Select Independent for seniors who do not need any assistance.
7	Feeding	Does senior require assistance with feeding?	Select Independent for seniors who do not need any assistance i.e. able to cut up/scoop their food and feed themselves. Examples of assistance/dependent: Needs assistance: Senior need someone to cut up their food, but they can eat it on their own. Dependent (Oral): Senior need someone to feed them the food. Dependent (NG Tube): Senior need use of Nasogastric tube for feeding. Dependent (PEG): Senior need use of Percutaneous Endoscopic Gastrostomy tube for feeding.
8	Urinary	Does senior require assistance with urinating?	Select Independent for seniors who do not need any assistance. Example of assistance: Senior need someone to bring him to toilet and need help to pull down his pants.
9	Bowel Management	Does senior require assistance with bowel movement?	Select Continent for seniors who do not need any assistance. For info: Colostomy and Ileostomy are both different types of stomas.