CLUB RAINBOW (SINGAPORE) REFERRAL FORM

(Club Rainbow (S) undertakes to protect the confidentiality of the information in this form)

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CHILD'S MEDICAL PARTICULARS

(To be completed by the Referring Physician)

Child's Data / Sticker

Child Name : _____

NRIC : _____

Date of Birth : _____

Citizenship : ☐ Singaporean ☐ PR

Gender : ☐ Male ☐ Female

Very Low Birth Weight Babies

(Birth Weight < 1500g)

Birth Weight : _____

Gestation : _____

ILLNESS GROUP CATEGORIES (PLEASE TICK ONLY ONE)

☐ Blood Disorders ☐ Immunological Disorders ☐ Metabolic Disorders ☐ Neurological Disorders

☐ Renal Disorders ☐ Cardiovascular Disease ☐ Respiratory Disease ☐ Developmental Paediatric

☐ Gastroenterology ☐ Rare Syndromes & Inborn Errors of Metabolism ☐ Very Low Birth Weight Infants

MAIN MEDICAL DIAGNOSIS: _____ Age at time of diagnosis: _____

_____

PROBLEM LIST:

1. _____
2. _____
3. _____
4. _____
5. _____

MEDICAL ALERT:

G6PD Deficiency : ☐ Yes ☐ No ☐ Unknown

Drug Allergies : ☐ Yes ☐ No

If Yes, please specify: _____

CURRENT THERAPY: _____

_____

MEDICATION: _____

_____

MOBILITY AND IMPAIRMENTS

☐ Wheelchair-bound ☐ Bed-bound ☐ Dresses Independently ☐ Feeds Independently

☐ Hearing Impaired ☐ Speech Delay ☐ Visually Impaired ☐ Attends Special School

☐ Able to travel by public transport ☐ Others : _____

SPECIAL CONSIDERATIONS : ☐ Restrictions in activity ☐ Diet ☐ Fluid intake needed

If yes, please specify: _____

REASON(S) FOR REFERRAL (PLEASE TICK WHERE APPLICABLE)

Please tick to the best knowledge on the type(s) of assistance required. Secondary assessment will be based on CRS Social Worker.

☐ Financial Assistance ☐ Counselling / Emotional Support ☐ Information on Illness ☐ Parent Support

☐ Therapy Services ☐ Educational / Tuition Support ☐ Transport (Mobility Issues) ☐ Social Programs

☐ Befriending Service ☐ Others: _____

DETAILS ON REFERRING PHYSICIAN

(Please ensure all fields are completed)

Physician Name & MCR : _____

Email Address : _____

Contact No : _____

Known to MSW : ☐ Yes ☐ No ☐ Unsure

Referring Hospital : _____

Signature : _____

Date : _____

MSW Name : _____

CLUB RAINBOW (SINGAPORE) BLK 538 UPPER CROSS STREET #05-263/ 269
TELEPHONE: 63771789 FAX: 62711789 WEBSITE: www.clubrainbow.org

MAIN CONTACT PERSON DETAILS (To be completed by Parent / Legal Guardian)

Main Contact Name	:	_____	NRIC	:	_____
Address	:	_____			
Relationship	:	_____	Contact No (Home)	:	_____
Email Address	:	_____	Contact No (Mobile)	:	_____
Language(s) Spoken	:	_____	Language(s) Written	:	_____

CONSENT

I consent to the Primary Physician who signed this form disclosing the personal data under 'Child's Medical Particulars' to Club Rainbow (Singapore) for the purpose of referring my child/ward to Club Rainbow (Singapore) so that it can consider whether my child/ward is eligible to be accepted for registration as a beneficiary of Club Rainbow (Singapore).

I also consent to Club Rainbow (Singapore) collecting the personal data that I have provided under 'Main Contact Person's Particulars' for the purpose of contacting me in connection with my child/ward being eligible to be registered as a beneficiary of Club Rainbow (S) and, if eligible, to arrange for registration.

* Signature of Main Contact Person: _____

Documents to be attached to this Referral Form:

1. If you are, or have been, involved in any matrimonial proceedings please attach a copy of all court orders made in those proceedings that might be relevant to the care or custody of the child.
2. If you are signing as the child's guardian, please attach a copy of the court order or other document appointing you as their legal guardian.
3. If the child's parents are unavailable and you are signing as the guardian of your ward but have not been legally appointed as their guardian, please provide documents giving the reason(s) why no parent is available to sign this Referral Form. These documents might include, for example, a medical report showing that they are mentally and/or physically incapable of signing this Referral Form, evidence of their incarceration or, if they cannot be located, a police report filed to report them as a missing person.

IMPORTANT NOTE:

Please ensure that all the sections of this form are **completed accurately and no material information is omitted**. All completed forms are to be placed in a sealed envelope and mailed or dispatched within the respective hospitals to:

Rainbow Care & Resource Centre – NUH
National University Hospital
Main Building (Level 4)
5 Lower Kent Ridge Road
Singapore 119074

Rainbow Care & Resource Centre – KKH
KK Women's and Children's Hospital
PEC, Women's Tower (Level 1)
100, Bukit Timah Road
Singapore 229899

Rainbow Family Care Centre
Blk 538 Upper Cross Street
#05-263 /269
Singapore 050538

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GUIDELINES FOR HOSPITAL MEDICAL PERSONNEL

All children aged 0 – 20 years who are Singaporeans and Permanent Residents with the following major chronic and potentially life-threatening medical conditions may be referred to join Club Rainbow (Singapore):

1. **BLOOD DISORDERS**
   - Marrow failure e.g. pure red cell Aplasia, Fanconi's Anaemia
   - Thalassemia Major and other chronic Haemolytic Anaemias
   - Chronic Idiopathic Thrombocytopenia
2. **CARDIOVASCULAR DISEASE**
   - Congenital Heart Defect
3. **DEVELOPMENTAL PAEDIATRIC**
   - Autism
   - Global Developmental Delay
4. **GASTROENTEROLOGY**
   - Inflammatory Bowel Disease
   - Chronic Liver Disease
   - Biliary Atresia
5. **IMMUNOLOGICAL DISORDERS**
   - Juvenile Chronic Arthritis
   - Systemic Lupus Erythematosus
6. **METABOLIC DISORDERS**
   - Diabetes Mellitus
   - Thyrotoxicosis / Hypothyroidism
   - Adrenal Insufficiency
7. **NEUROLOGIC DISORDERS**
   - Muscular Dystrophies / Myopathies
   - Spina Bifida
   - Cerebral Palsy
8. **RENAL DISORDERS**
   - Chronic / End-Stage Renal Failure
   - Nephrotic Syndrome with complications
9. **RARE SYNDROMES AND INBORN ERRORS OF METABOLISM**
   - Mitochondria Disease
   - Organic Acidaemia
   - Fatty Acid Oxidation Disorders
   - DiGeorge Syndrome
   - Angelman Syndrome
   - Other Rare Syndromes
10. **RESPIRATORY DISEASE**
    - Chronic Asthma
11. **VERY LOW BIRTH WEIGHT INFANTS (BIRTH WEIGHT <1500g) WITH EITHER:**
    - Visual / Hearing Impairment
    - Chronic Lung Disease
    - Developmental Delay

NOTE:

Patients with other medical conditions/chronic illnesses/disabilities which are not included in specific support organizations may be considered for support by Club Rainbow on a case by case basis. This will be subject to approval by the Medical Subcommittee of the charity.

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