SG ENABLE

Inclusive society, Enabled lives.

EIPIC/ICCP REFERRAL FORM

BEFORE YOU FILL IN THIS FORM, PLEASE TAKE NOTE:

- The Early Intervention Programme for Infants & Children (EIPIC) provides therapy and educational support services for infants and young children with special needs. It equips them with necessary skills and helps develop their potential, thereby minimising disabilities.
- The Integrated Child Care Programme (ICCP) is an inclusive child care programme for children with mild special needs. Providing these children with a natural learning environment alongside mainstream peers will help prepare them for future entry into mainstream primary education.
- To refer a child to EIPIC or/and ICCP, please submit the attached 1) Referral Form, 2) Annex A (Social Report), and 3) Annex B (Medical Report), together with all supporting documents (if applicable).
- SG Enable reserves the right to reject any application that is incomplete, not supported by the necessary documents, or does not meet the eligibility criteria of the programme.

CONTACT US:

Infoline: 1800 8585 885
Website: www.sgenable.sg

ELIGIBILITY

- Singapore Citizen or Permanent Resident
- EIPIC: 0 to 6 years old who are diagnosed with developmental, intellectual, sensory or physical disabilities or a combination of disabilities
- ICCP: 2 to 6 years old who are diagnosed with mild disabilities such as physical, hearing, visual or speech impairments or developmental delays

SUPPORTING DOCUMENTS

- Permanent Resident supporting documents, if applicable
- Legal guardianship documents, if applicable

IMPORTANT NOTES

- The completed referral form must be signed by the parent/legal guardian
- Annex A (Social Report) and Annex B (Medical Report) must be completed and signed by a relevant qualified professional

SEND APPLICATION TO

Mailing Address: SG Enable
20 Lengkok Bahru, #01-01, Singapore 159053

Email: contactus@sgenable.sg

Please tick ☑ where applicable
*Please circle which applies

A. CHILD'S PARTICULARS

Surname:

Given Name:

Citizenship: ◯ Singaporean ◯ Permanent Resident

Identification Number:

Date of Birth: (DD/MM/YYYY) / /

Gender: ◯ Male ◯ Female

Address:

Postal Code: S

Unit No.: # -

#0-0 if there is no unit no.

Religion:

B. FAMILY PARTICULARS

Father/Legal Guardian*

Surname:

Given Name:

◯ Primary Caregiver ◯ Main Contact Person

Identification Number:

Citizenship: ◯ Singaporean ◯ Permanent Resident ◯ Others (please specify)

Date of Birth: (DD/MM/YYYY) / /

Gender: ◯ Male ◯ Female

Educational Level:

Main Language Spoken:

Occupation/ Job Title:

Contact (Office):

Contact (Home):

Gross Monthly Income ($):

Contact (Mobile):

Email:

Preferred Contact Method: ◯ Mobile ◯ Home ◯ Office ◯ Email ◯ NA

Please tick ☑ where applicable
*Please circle which applies

B. FAMILY PARTICULARS (CONT'D)

Mother/Legal Guardian*

Surname:

Given Name:

◯ Primary Caregiver ◯ Main Contact Person Identification Number:

Citizenship: ◯ Singaporean ◯ Permanent Resident ◯ Others (please specify)

Date of Birth: (DD/MM/YYYY) / /

Gender: ◯ Male ◯ Female

Educational Level:

Main Language Spoken:

Occupation/ Job Title:

Contact (Office):

Contact (Home):

Gross Monthly Income ($):

Contact (Mobile):

Email:

Preferred Contact Method: ◯ Mobile ◯ Home ◯ Office ◯ Email ◯ NA

OTHER FAMILY MEMBERS (Living in the same household)

Name	Relationship	D.O.B. (DD/MM/YYYY)	Occupation/ Job Title	Gross Monthly Income (if applicable)	Contact Number (Optional)

Please tick ☑ where applicable
*Please circle which applies

C. DECLARATION

1. I declare to the best of my knowledge and belief that the particulars furnished are true and correct.
2. I understand that I am obliged to abide by the regulations/agreements laid down by the organisation/institution involved.
3. I have been informed that in the course of processing the application, it may be necessary for the Referring Agency to disclose/transfer relevant information pertaining to me/my household to other agencies.
4. I understand that the disclosure of such information is necessary to facilitate the application for the Centre. I also hereby do give my consent for the release/disclosure of such information to the relevant bodies to facilitate consideration of the application.

Signature of Parent/ Legal Guardian	Name	Relationship to Child
Identification Number	Date	

Please tick ☑ where applicable
*Please circle which applies

A. CHILD'S PARTICULARS

Surname:

Given Name:

Identification Number:

Citizenship: ◯ Singaporean ◯ Permanent Resident

Age:

Date of Birth: (DD/MM/YYYY)

Gender: ◯ Male ◯ Female

B. GENOGRAM

Draw a genogram of the immediate family and significant family members.
(Include the age, occupation and other important information about the person.)

Please tick ☑ where applicable
*Please circle which applies

C. FAMILY BACKGROUND

FAMILY SIZE

- ◯ Nuclear family of 3. Patient is the only child
- ◯ Nuclear family of _____. Patient has _____sibling(s)
- ◯ Family has extended family living with them, please indicate: _____
- ◯ Parents have a foreign domestic helper

ACCOMMODATION

- ◯ The family is living in a _____-room HDB flat
- ◯ The family is living in a condominium/private property*
- ◯ The family is renting a _____ -room HDB/private housing*

CHILDCARE SUPPORT

MAIN CAREGIVER

- ◯ Mother
- ◯ Father
- ◯ Domestic helper
- ◯ Maternal grandparent(s)
- ◯ Paternal grandparent(s)
- ◯ Others (Please specify): _____

SOCIAL SUPPORT NETWORK

- ◯ Parents have a lot of support from paternal/maternal grandparent(s)*
- ◯ Parents have some childcare support from extended family as and when required
- ◯ Parents have very little or no support from extended families
- ◯ Parents have support from friends/neighbours*
- ◯ Others (Please specify): _____

Please tick ☑ where applicable
*Please circle which applies

D. PARENTS'/CAREGIVER'S AWARENESS AND ACCEPTANCE OF DISABILITY

PARENTS'/CAREGIVER'S ACCEPTANCE OF CHILD'S CONDITION

- ◯ Parents/Caregiver* are/is still in denial of child's condition
- ◯ Father is coming to terms with child's condition but mother is still in denial
- ◯ Mother is coming to terms with child's condition but father is still in denial
- ◯ Parents/Caregiver* are/is coming to terms with child's condition
- ◯ Parents/Caregiver* have/has accepted child's condition well
- ◯ Others (Please specify): _____

PARENTS'/CAREGIVER'S UNDERSTANDING OF CHILD'S CONDITION

- ◯ Parents/Caregiver* have/has some understanding of child's condition
- ◯ Parents/Caregiver* do/does not have a clear understanding of child's condition
- ◯ Father/Mother* agrees with the suspected/confirmed diagnosis
- ◯ Parents agree/disagree* with the suspected/confirmed diagnosis
- ◯ Father/Mother* disagrees with the suspected/confirmed diagnosis
- ◯ Caregiver agrees/disagrees* with the suspected/confirmed diagnosis
- ◯ Parents/Caregiver* have/has received a lot of information and resource knowledge on child's diagnosis
- ◯ Others (Please specify): _____

PARENTS'/CAREGIVER'S AWARENESS OF CHILD'S CONDITION

- ◯ Parents/Caregiver* noticed some signs of delayed development when child was 1–2 years old and decided to bring child for a check-up
- ◯ Parents/Caregiver* noticed some signs of delayed development but wanted to monitor further
- ◯ Parents/Caregiver* noticed some signs of delayed development but thought that child would "outgrow" this if given more time
- ◯ Parents/Caregiver* were/was alerted by childcare/preschool teacher*
- ◯ Parents/Caregiver* were/was alerted by an extended family member/friend/neighbour*
- ◯ Others (Please specify): _____

PARENTS'/CAREGIVER'S MOTIVATION IN HELPING TO FACILITATE CHILD'S DEVELOPMENT

- ◯ Parents/Caregiver* are/is keen to help child overcome his/her difficulties
- ◯ Parents/Caregiver* feel(s) helpless due to a lack of skills/knowledge to facilitate child's development
- ◯ Father/Caregiver* is very involved/uninvolved* in the care and management of child
- ◯ Mother is very involved/uninvolved* in the care and management of child
- ◯ Others (Please specify): _____

Please tick ☑ where applicable
*Please circle which applies

E. COMMUNITY INTERVENTIONS

LIST OF COMMUNITY RESOURCES/VWOS THAT ARE ASSISTING THE CHILD/FAMILY

◯ The child is now attending a daily half-day/full-day* childcare programme with

_____

◯ The child is attending private intervention/speech therapy/occupational therapy* sessions with

_____

◯ The family is now receiving financial aid/counselling* from an external agency

_____

F. SOCIAL ASSESSMENT

◯ Parents/Caregiver* seem(s) to be coming to terms with child's condition

◯ Parents/Caregiver* seem(s) to be in denial

◯ Parents/Caregiver* appear(s) to be open about placing child in the EIPIC/ICCP Programme

◯ The family has financial difficulties and parents/caregiver* are/is concerned about affordability of the EIPIC/ICCP Programme

◯ Others (Please specify):

G. RECOMMENDATIONS

◯ Parents/Caregiver* have/has requested for financial aid/subsidy* for the monthly EIPIC/ICCP fees

◯ Parents/Caregiver* are/is anxious about the long waiting period and have requested for child to be placed in an EIPIC/ICCP Centre as soon as possible

◯ Others (Please specify): _____

Report Prepared by:

Name: _____ Signature: _____

Designation: _____ Organisation: _____

Contact No.: _____ Fax No.: _____

Email: _____ Date: _____

Please tick ☑ where applicable
*Please circle which applies

A. DIAGNOSIS

PRINCIPAL DIAGNOSIS: ◯ **Confirmed** ◯ **Suspected**

◯ ADHD ◯ ASD ◯ Cerebral Palsy ◯ Dyslexia
◯ GDD[#] ◯ Hearing impairment ◯ Intellectual disability
◯ Physical disability ◯ Speech & language ◯ Visual impairment

Other diagnosis (Please specify): _____

Cause: ◯ Unknown ◯ Specify: _____

Level of functioning:
◯ Mild (D) ◯ Mild-Moderate (C) ◯ Moderate-Severe (B) ◯ Severe (A)

B. HISTORY

BIRTH AND POSTNATAL HISTORY

_____
_____
_____

DEVELOPMENTAL MILESTONES

◯ Delayed since: ◯ Infancy ◯ Early childhood
◯ Normal initially, but delayed since sustaining cerebral injury at (age)
◯ Developmental regression
◯ Others (Please specify): _____
◯ Information not available

MEDICAL HISTORY (You may tick more than one box)

◯ None
◯ Epilepsy
◯ Swallowing dysfunction on: ◯ tubefeeding ◯ gastrostomy ◯ special diet
◯ Gastroesophageal reflux
◯ Failure to thrive
◯ Reactive airway disease/asthma
◯ Involuntary movements (Please specify): _____
◯ Others (Please specify): _____

OTHER PHYSICAL ABNORMALITIES (DYSMORPHIC FEATURES)

◯ Yes (Please specify): _____ ◯ No

[#] Global Developmental Delay (GDD) is defined as significant delay in two or more developmental domains.

Please tick ☑ where applicable
*Please circle which applies

B. HISTORY (CONT'D)

CURRENT MEDICATIONS (State doses)
_____
_____
ALLERGIES (Drugs/food, if any)
_____
_____
FAMILY HISTORY OF ANY RELEVANCE TO DISABILITY
_____
_____

C. CURRENT STATUS

PHYSICAL ASSESSMENT		Percentiles
Weight	_____	_____
Height	_____	_____
Head Circumference	_____	_____
Date	_____	_____

HEARING ASSESSMENT

- ◯ Suspected hearing impairment
- ◯ Grossly normal: ◯ Responds to sound ◯ Understands verbal commands
- ◯ Hearing test:
  - ◯ Not done
  - ◯ Pending. Date:
  - ◯ Done. Date performed:
  - ◯ Instrument/test:
    - ◯ Otoacoustic Emission (OAE)
    - ◯ Automated Auditory Brainstem Response (AABR)
    - ◯ Brainstem Auditory Evoked Response (BAER)
    - ◯ Others (Please specify):
  - ◯ Normal
  - ◯ Abnormal (Please specify):
  - ◯ Hearing aids

Please tick ☑ where applicable
*Please circle which applies

C. CURRENT STATUS (CONT'D)

VISUAL ASSESSMENT

- ◯ Suspected visual impairment
- ◯ Grossly normal i.e. Visually fixates and follows in all directions fairly well
- ◯ Visual assessment:
  - ◯ Not done
  - ◯ Pending. Date: _____
  - ◯ Done. Date performed: _____
  - ◯ Normal
  - ◯ Abnormal (Please specify):
    - ◯ Myopia
    - ◯ Hypermetropia
    - ◯ Astigmatism
    - ◯ Others (Please specify): _____
  - ◯ Visual aids

PSYCHOLOGICAL ASSESSMENT (Please attach relevant assessments)

- ◯ Done
- ◯ Not done
- ◯ Pending. Date: _____

D. DEVELOPMENTAL STATUS

GROSS MOTOR MILESTONES

- ◯ Within normal limits
- ◯ Delay: ◯ mild ◯ moderate ◯ marked

MOTOR TONE

- ◯ Within normal limits
- ◯ Abnormal (Please specify):
  - ◯ Diffuse hypotonia
  - ◯ Axial hypotonia with spasticity of the limbs
  - ◯ Hemiplegia
  - ◯ Diplegia
  - ◯ Quadriplegia
  - ◯ Double hemiplegia
  - ◯ Others (Please specify): _____

Please tick ☑ where applicable
*Please circle which applies

D. DEVELOPMENTAL STATUS (CONT'D)

AMBULATORY STATUS (You may tick more than one box)

FOR ALL CHILDREN

- ◯ Totally non-ambulatory i.e. bedridden or wheelchair bound
- ◯ Totally dependent on others for activities of daily living
- ◯ Able to move with assistive devices (walker, rollator, wheelchair, etc.)
- ◯ Independent gait: ◯ normal gait ◯ abnormal gait (Please specify): _____

FOR INFANTS/TODDLERS

- ◯ Able to roll over
- ◯ Able to sit independently
- ◯ Able to crawl
- ◯ Able to stand with support and/but not cruise
- ◯ Others (Please specify): _____

FINE MOTOR SKILLS

- ◯ Appropriate for age
- ◯ Delayed (Please specify): _____
  _____
- ◯ Information not available

LANGUAGE & COMMUNICATION (You may tick more than one box)

- ◯ Mute
- ◯ Vocalisation, cooing
- ◯ Babbling, no intelligible words
- ◯ Single words mainly (including papa, mama)
- ◯ 2-to 4-word sentences
- ◯ Talks in complete sentences
- ◯ Able to request
- ◯ Quality of speech, if available
- ◯ Poor communicative intent
- ◯ Use of gestures
- ◯ Others (Please specify): _____
  _____
- ◯ Information not available
- ◯ Unable to assess

Please tick ☑ where applicable
*Please circle which applies

D. DEVELOPMENTAL STATUS (CONT'D)

SOCIAL BEHAVIOURAL SKILLS & OBSERVATIONS (You may tick more than one box)

- ◯ Within normal limits
- ◯ Poor eye contact/joint attention
- ◯ Poor social interaction
- ◯ Hyperactive
- ◯ Passive
- ◯ Aggressive/self-injurious behaviour

Other behavioural observations (Please specify): _____

COGNITIVE FUNCTION

- ◯ Fairly appropriate for age
- ◯ Mild to moderate cognitive delay
- ◯ Severe cognitive delay – requires assistance from others in activities of daily life
- ◯ Unable to assess

Other remarks: _____

_____

E. RECOMMENDATION AND REFERRAL

This child is recommended for the following service type

- ◯ ICCP
- ◯ EIPIC (Please indicate type of programme recommended)
  - ◯ Early Intervention for Autism Spectrum Disorder
  - ◯ Early Intervention for Global Developmental Delay
  - ◯ Early Intervention for other disabilities (Please specify): _____

Remarks/Comments (e.g. Any specific activities beneficial for the child): _____

_____

_____

Name of Doctor/Staff: _____ MRN: _____
Hospital/Clinic/Department: _____
Contact No: _____
Email: _____
Date of Referral: _____

Signature: _____ Stamp: _____