Abilities Beyond Limitations and Expectations Ltd

An Affiliate of Caritas-Singapore
Company Registration No. 201022774G
7A Toa Payoh Lorong 8 #02-09 Singapore 319264
Tel: 6801 7460 | Email: enquiries@able-sg.org | Website: www.able-sg.org

ABLE Rehabilitation & Employment Application Form

Notes:

- ***Page 1 & 2** must be completed to expedite processing of application.*
- ***Page 2 must be completed by a Singapore Registered Medical Practitioner***
- ***Page 3** is required for application submitted by a referral agency/organisation e.g., by case manager/social worker/care coordinator*

Application form and relevant documents, may be submitted via

(1) email to: enquiries@able-sg.org ***(2) hand-in at ABLE office** (address above)* ***(3) post to ABLE office** (address above)*

SECTION 1 SERVICES REQUIRED

☐ **Rehabilitation** *(PT / OT / ST Services)* ☐ **Employment Services** *(for Return-to-Work)*

SECTION 2 APPLICANT DETAILS

Name:					
NRIC:			**Date of Birth:**		
Gender:	☐ Male	☐ Female	**Age:**		
Contact Details:	(Home)		(Mobile)		
	(Email)				
Address:			Postal Code:		
Citizenship:	☐ Singaporean	☐ Permanent Resident	☐ Others:		
Race:	☐ Chinese	☐ Indian	☐ Malay	☐ Eurasian	☐ Others:
Language(s) Spoken:					
Marital Status:	☐ Single	☐ Married	☐ Widowed	☐ Separated	☐ Divorced
Religion:					
Housing:	☐ Private House/Apartment	☐ HDB; lift-landing:	☐ Yes	☐ No; _______steps	

SECTION 3 NEXT OF KIN DETAILS / CARE INFORMATION

Next of Kin:			**Relationship with Applicant:**	
Contact No.:	(Home)		(Mobile)	
Language:	☐ English	☐ Mandarin	☐ Malay	☐ Others:
Main Caregiver:			**Relationship with Applicant:**	

Currently attending community/rehabilitation service? ☐ No ☐ Yes, Please Specify: ________________________

Currently receiving any social/community care service? ☐ No ☐ Yes, Please Specify: ________________________

Contact Name: Organisation: Email / Tel.:

SECTION 4 EMPLOYMENT INFORMATION *(Required for applicants that require Employment Services only)*

Highest Education Qualification:	☐ No formal	☐ Primary	☐ Secondary
	☐ Polytechnic Diploma	☐ University Degree	☐ Postgraduate
Previous Employment:	☐ Full-time ☐ Part-time	Job Designation / Role:	
	Industry:	Employment Status: ☐ Employed; on MC until _________	☐ Unemployed
Future Employment:	☐ Full-time ☐ Part-time		
	Preferred type of work:		

SECTION 5 APPLICANT CONSENT

By signing this application, the Applicant/Next-of-Kin consent to the disclosure of information in this application to Caritas-Singapore / relevant agencies or service providers, as required.

**Please complete Page 3 Section 1 & 2 if unable to attain Applicant/Next-of-Kin signature for consent.*

Applicant Signature: **Date:**

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This page 2 must be completed by a Singapore Registered Medical Practitioner

*** If available, please attach any latest discharge summary or therapy status report. Thank you.*

SECTION 6 APPLICANT MEDICAL HISTORY

Summary of **Medical Conditions / Diagnosis** : *(please attach memo if insufficient space)*

Summary of **Investigations & Management** to-date *(including any recent surgical interventions)* :

Current Medication:

Drug Allergy: ☐ No ☐ Yes, Please Specify:

Does the person have any active infectious disease? ☐ No ☐ Yes, Please Specify:

Precautions: ☐ Nil ☐ Contact ☐ Droplet ☐ Others:

Are there any medical precautions to be taken or conditions that would require close monitoring?

☐ No ☐ Yes, Please Specify:

SECTION 7 APPLICANT CURRENT FUNCTIONAL STATUS

Cognitive impairment: ☐ No ☐ Yes, Please Specify:
Disruptive behaviours: ☐ No ☐ Yes, Please Specify:
Psychiatric symptoms: ☐ No ☐ Yes, Please Specify:

Visual impairment: ☐ No ☐ Yes, Please Specify:
Hearing impairment: ☐ No ☐ Yes, Please Specify:
Speech impairment: ☐ No ☐ Yes, Please Specify:

Mobility Status: ☐ Wheelchair ☐ Ambulant/Walking; Assistance level: ___________________________________
Walking Aid: ☐ Nil ☐ Walking Stick ☐ Quadstick ☐ Walking Frame ☐ Others: ________________________

Bathing/Showering:	☐ Independent	☐ Needs Assistance
Dressing:	☐ Independent	☐ Needs Assistance
Feeding:	☐ Independent	☐ Needs Assistance
Toileting:	☐ Independent	☐ Needs Assistance
Transfers:	☐ Independent	☐ Needs Assistance
Bowel/Bladder Control:	☐ Continent	☐ Incontinent

SECTION 8 FITNESS FOR REHABILITATION

The applicant **is fit** to undergo rehabilitation at the following **load/duration**:

☐ Light loading / 60 to 120 minutes ☐ Medium loading / 120 to 240 minutes ☐ Heavy loading / as required for RTW

Precautions / Restrictions during rehabilitation:

SECTION 9 MEDICAL PRACTITIONER PARTICULARS

☐ **OPTION A: Please provide the following details**	☐ **OPTION B: Doctor Referral Letter** (*In the event that Dr is unable to sign on this application form*)
Name of Doctor: **Signature:** **MCR No.:** **Hospital/Clinic:** **Email/Tel:** **Date:**	**Please ensure that the following details are included in the letter to be attached:** 1) Main purpose of referral to ABLE 2) Doctor Details: Please include details stated in **Option A**

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This page 3 is to be completed if application is submitted by the referral agency/organisation.

SECTION 1 CONSENT FOR REFERRAL

To enable ABLE to process this application, the applicant / next-of-kin must agree to this referral, so that ABLE may begin to contact them directly and, consent to the disclosure of information in this application to Caritas – Singapore / relevant agencies or service providers, as required.

Applicant / Next of Kin **agreed** to this referral and consent was given on:

Consent given by: ☐ Applicant ☐ Next-of-Kin (Name):

SECTION 2 REFERRAL SOURCE DETAILS

Name:	**Designation:**	**Signature:**
Organisation:	**Email / Tel. No. :**	**Date:**

SECTION 3 SOCIAL / FINANCIAL INFORMATION *(if financial assistance is required for ABLE services)*

Singapore Household Means-Testing Completed? ☐ Yes ☐ No

If **yes**, please state the approved subsidy level: _____________% Valid until: _______________

If **no**, please provide any information on applicant's family / living / care / financial arrangements (or attach latest social report / financial information) that will assist ABLE to expedite assessment for financial assistance.

Click or tap here to enter text.

Currently receiving any social/community care service? ☐ No ☐ Yes, Please Specify: _______________________

Contact Name: Organisation: Email / Tel.:

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FITNESS TO WORK ASSESSMENT (ONLY IF REFERRING FOR RETURN-TO-WORK SERVICES)

To be filled up by a Medical Doctor for the purpose of the application for the Hospital-to-Work Programme and related schemes under SG Enable, of which ABLE serves as a service provider.

Name of Patient: ______________________ NRIC No.: ______________________

MEDICAL CONDITION

Diagnosis: ______________________

Onset of Current Diagnosis: ______________________

(a) Cognitive & Work-Related Functioning

Please indicate any deficits affecting work performance and functioning in the following areas:

1. Attention & Memory Function ☐ No ☐ Yes
2. Executive Function ☐ No ☐ Yes
3. Communication & Social Interaction Skills ☐ No ☐ Yes
4. Initiation & Adaptation ☐ No ☐ Yes

(b) Physical Functioning & Mobility

1. Residual physical limitations: ☐ No ☐ Yes, please specify type below:
   ☐ Vision ☐ Hearing ☐ Upper Limb (Right/Left/ Both) ☐ Lower Limb (Right/Left/Both)
2. Ability to travel independently in community: ☐ No ☐ Yes
3. Usage of mobility aids: ☐ No ☐ Yes, please specify aid below:
   ☐ Manual/Motorised Wheelchair ☐ Walking Aid ☐ Prothesis/Orthosis

(c) Other Medical Conditions

Please specify any other medical precautions or conditions that require close monitoring:

☐ No ☐ Yes, please specify: ______________________

TYPE OF DISABILITY *(To be filled up by Medical Doctor only)*

☐ Cognitive Disability ☐ Physical Disability ☐ Others:

Please indicate if the nature of the disability stated above is **(CHOOSE ONLY ONE)**:

☐ Likely to remain for 3-6 months ☐ Likely to remain permanent

☐ Likely to remain for 7-12 months ☐ Others: ______________________

FITNESS FOR WORK *(To be filled up by Medical Doctor only)*

☐ Yes ☐ No	If yes, please specify: ☐ Patient will be medically fit for employment in the next __________ months. ☐ Patient is medically fit for employment. ☐ Patient is medically fit for specific job/work (light duty/non heavy work/carrying work) Please specify: ______________________

ASSESSOR CERTIFICATION

Name/ Signature:		Official Stamp of hospital/clinic:
MCR no.:	Date:	