

CHPC provides affordable psychological interventions for individuals, couples & families. Please return completed form to CHPC via fax (65) 6773-1361 or email to chpc.enquiries@nus.edu.sg. The client will receive a triage call within 2-3 working days to assess their suitability for CHPC. We will let you know the outcome of the triage via your preferred mode of communication. For any enquiries, please contact us at (65)6516-5322

***CLIENT INFORMATION					
Patient's Surname: <input type="text"/>		Given: <input type="text"/>		Title: <input type="checkbox"/> Mr <input type="checkbox"/> Ms <input type="checkbox"/> Mdm <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/> Master	
IC No:	Email Address:	**Contact No:	Birth date (DD/MM/YY)	Age:	Gender:
					<input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> Other
Marital status:	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	Preferred Language:		<input type="checkbox"/> English <input type="checkbox"/> Mandarin <input type="checkbox"/> Malay <input type="checkbox"/> Others	
Address:					
Caregiver's Name: <input type="text"/>		Caregiver's Contact: <input type="text"/>		Relationship: <input type="text"/>	
*Applicable only if client is below 18 years old **Mobile number is preferred in contacting client.					
***Please note that no clinical information goes on to the National Electronic Health Record.					
CLINICAL INFORMATION					
Reason for Referral (please tick relevant difficulties):					
Anxiety, Worry <input type="checkbox"/>	Body Image <input type="checkbox"/>	Emotion Regulation <input type="checkbox"/>	Perfectionism <input type="checkbox"/>	OCD <input type="checkbox"/>	Others <input type="checkbox"/>
ADHD not available	Bullying <input type="checkbox"/>	Health Anxiety <input type="checkbox"/>	Personality <input type="checkbox"/>	Self-Harm <input type="checkbox"/>	
ASD not available	Brain Injury <input type="checkbox"/>	Interpersonal <input type="checkbox"/>	Phobia <input type="checkbox"/>	Self-Esteem <input type="checkbox"/>	
Anger <input type="checkbox"/>	Depression <input type="checkbox"/>	Learning Difficulty <input type="checkbox"/>	Panic <input type="checkbox"/>	Stress <input type="checkbox"/>	
Bipolar <input type="checkbox"/>	Eating Disorder <input type="checkbox"/>	Marital / Relationship <input type="checkbox"/>	PTSD <input type="checkbox"/>	Sleep Disorder <input type="checkbox"/>	
Elaboration of Diagnosis:					
Relevant History:					
Other Remarks:					
REFERRAL INFORMATION					
Name of Referrer: <input type="text"/>		Mobile: <input type="text"/>	Office no: <input type="text"/>	Email add: <input type="text"/>	
Department / Organization: <input type="text"/>		<input type="text"/>	<input type="text"/>	<input type="text"/>	