SG ENABLE
Inclusive society, Enabled lives.

APPLICATION FOR ADULT DISABILITY SERVICES

Please tick ✓ where applicable

Name of Applicant: ____________________________

NRIC / BC No.: ____________________________

M. MEDICAL INFORMATION

Medical Information is not mandatory if the applicant has any medical proof of his/ her disability condition and does not have any past or presenting health condition. Otherwise, applicant may approach a medical practitioner to complete the Medical Information.

A social worker from the referring agency may share additional medical background of the applicant on page 18 and 19, if a medical report is submitted together for the application.

1M. TYPE OF DISABILITY (Multiple Selection Allowed)

Diagnosis	Intellectual Disability (IQ: Below 70)	Borderline ID (IQ:70 - 80)	Primary Diagnosis
☐ Intellectual Condition	○	○	○

Diagnosis	Partial Impairment	Total Impairment	Primary Diagnosis
☐ Sensory (Visual):	○	○	○
☐ Sensory (Hearing):	○	○	○
☐ Sensory (Others):	○	○	○

Diagnosis	Mild	Moderate	Severe	Primary Diagnosis
☐ Sensory (Others):	○	○	○	○
☐ Physical Disability (Please Specify):	○	○	○	○
☐ Developmental Condition (Please Specify):	○	○	○	○
☐ Others (Please Specify):	○	○	○	○

2M. MEDICAL HISTORY

(a) Mental or psychiatric disorders

○ No ○ Yes, Please Specify: ______________________________

Condition ○ Mild ○ Moderate ○ Severe

(b) Infectious Diseases

○ No ○ Yes, Please Specify: ______________________________

Following Up: ○ Yes ○ No ○ Discharged ○ Defaulted

Date of Last Follow-up: ________________ Hospital/Clinic: ________________

Condition: ○ Active or highly contagious ○ Persistent and asymptomatic

○ No longer infectious or contagious

Please tick ✓ where applicable

M. MEDICAL INFORMATION (CONTINUED)

(c) Medical Conditions

- ☐ Respiratory: ______________
- ☐ Neurological Disorder: ______________
- ☐ Cardiovascular: ______________
- ☐ Musculoskeletal: ______________
- ☐ Endocrine/Metabolic: ______________
- ☐ Dermatological Conditions: ______________
- ☐ Other condition(s) not specified above: ______________

If any of the above is ticked, please elaborate (e.g. frequency of occurrence): ______________

____

(d) Did the patient undergo any surgery within the last two years? If yes, please provide brief details below.

	Date	Surgery Done
○ No ○ Yes		

(e) Is the patient currently on any medication? If yes, please specify below.

○ No ○ Yes	1.	3.
	2.	4.

(f) Does the patient have any drug allergies? If yes, please specify below.

○ No ○ Yes	1.	3.
	2.	4.

(g) Does the patient have any food allergies? If yes, please specify below.

○ No ○ Yes	1.	3.
	2.	4.

(h) Does the patient have any regular follow-ups? If yes, please specify below.

	Types of follow-up	Frequency
○ No ○ Yes		

3M. DOCTOR'S CERTIFICATION – IF APPLICABLE

______________	______________	______________
Name of Doctor	Signature.	Date
______________	______________	______________
Contact No	MCR No.	Official Stamp of Hospital/Clinic