FEI YUE COMMUNITY SERVICES
Community Resource Engagement and Support Team (CREST)
REFERRAL FORM

To refer a case, please email the **completed referral form** *to the respective programme administrator.*

Team	Contact	Email
CREST @ Ang Mo Kio-Hougang, Hougang SMC and Punggol (under Bedok Reservoir-Punggol constituency)	*6011 7650*	**crest@fycs.org**
CREST @ Brickland and Choa Chu Kang	*6011 7654*	
CREST @ Bukit Panjang SMC, Cashew and Zhenghua	*6011 7653*	
CREST @ Bukit Timah, Clementi and Ulu Pandan	*6011 7652*	
CREST @ Buona Vista and Queenstown	*6011 7651*	
CREST @ Limbang and Yew Tee	*6011 7655*	
CREST @ Paya Lebar and Serangoon	*6011 7656*	

SECTION 1: REFERRAL DETAILS	
Referral organisation: Click here to enter text	*Date of referral:* Click here to select date
Name of referring staff: Click here to enter text	*Designation:* Click here to enter text
Contact no.: Click here to enter text	*Email:* Click here to enter text

SECTION 2: PERSONAL DATA PROTECTION ACT

The privacy of your personal data is important to us, and we are committed to accord the information the due level of care as presented in our Personal Data Protection Policy and consistent with the Personal Data Protection Act 2012. Our Policy Statement is available on Fei Yue's website at the following link: https://www.fycs.org/data-protection-policy/. With effect from 2 July 2014, this policy forms part of the conditions in relation to the services that we provide for you.

☐ *Client / caregiver has consented to this referral and agreed to the disclosure of the enclosed information to the relevant agencies / service providers to facilitate the referral.*

SECTION 3: CRITERIA FOR REFERRAL

CREST: Community Resource, Engagement and Support Team

CREST serves as a basic community safety network to support those at risk of / with mental health conditions, and caregivers who need the additional support to care for their loved ones.

Updated 16th May 2025

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Criteria for CREST:
(please check the respective boxes, where applicable)

- *Client is at least 18 years old,* **and**
- *Client lives in the following area:* *(please check only 1 box)*

☐ *CREST @ Ang Mo Kio-Hougang / Hougang SMC / Punggol (under Bedok Reservoir-Punggol constituency)*
☐ *CREST @ Brickland / Choa Chu Kang*
☐ *CREST @ Bukit Panjang SMC / Cashew / Zhenghua*
☐ *CREST @ Bukit Timah / Clementi / Ulu Pandan*
☐ *CREST @ Buona Vista / Queenstown*
☐ *CREST @ Limbang / Yew Tee*
☐ *CREST @ Paya Lebar / Serangoon*

Reason(s) for referral: *(you may check more than 1 box)*
☐ *Client is suspected to have mental health condition*
☐ *Client is diagnosed with mental health condition and requires support in the community*
☐ *Caregiver is experiencing stress with his/her loved one(s)*

Service(s) required: *(you may check more than 1 box)*
☐ *Basic screening of mental health condition (dementia, depression etc.)*
☐ *Liaison and navigation for community and mental health services*
☐ *Basic emotional support to clients and/or caregivers*
☐ *Psychoeducation on management of mental health condition*

SECTION 4: CLIENT'S PARTICULARS		
Name: Click here to enter text		*NRIC:* Click here to enter text
Gender: ☐ *Female* ☐ *Male*	*Date of Birth:* Click here to select date	*Age:* Click here to enter text
Address: Click here to enter text		
Contact no.: Click here to enter text		
Employment status:	☐ *Employed full-time* ☐ *Employed part-time* ☐ *Retired* ☐ *Unemployed* ☐ *Student*	
Occupation: Click here to enter text *(if employed)*		*Race:* Click here to enter text
Marital status: Click here to enter text		*Citizenship:* Click here to enter text
Language(s) spoken:	☐ *English* ☐ *Mandarin* ☐ *Malay* ☐ *Tamil* ☐ *Cantonese* ☐ *Hakka* ☐ *Hokkien* ☐ *Hainanese* ☐ *Teochew* ☐ *Others:* Click here to enter text	
Religion:	☐ *Buddhism* ☐ *Christianity* ☐ *Hinduism* ☐ *Islam* ☐ *Sikhism* ☐ *Taoism* ☐ *Freethinker*	

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	☐ *Others: Click here to enter text*		
Home ownership:	☐ *Rental*	☐ *Purchased*	☐ *Free lodging*
	☐ *Others: Click here to enter text*		
Current living arrangement:	☐ *Family*	☐ *Relatives*	☐ *Alone, without helper*
	☐ *Alone, with helper*	☐ *Friends*	☐ *Others: Click here to enter text*
Type of housing:	☐ *HDB Click here to select 1/2/3/4/5 room*		☐ *HDB Executive Apartment*
	☐ *HDB Elderly Studio Apartment*		☐ *Private Property*
	☐ *Others: Click here to enter text*		
Highest education level:	☐ *No education*	☐ *Lower primary*	☐ *Upper primary*
	☐ *Lower secondary*	☐ *Upper secondary*	☐ *Post-secondary*

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SECTION 5: CAREGIVER / EMERGENCY CONTACT	
Name: Click here to enter text	
Relationship to client: Click here to enter text	*Contact no.:* Click here to enter text

SECTION 6: CLIENT'S CLINICAL INFORMATION			
Psychiatric diagnosis: *(if any)*	☐ *Dementia* ☐ *Bipolar disorder* ☐ *Personality disorder*	☐ *Depression* ☐ *Delusional disorder* ☐ *Schizophrenia*	☐ *Anxiety* ☐ *Obsessive-compulsive disorder* ☐ *Others:* Click here to enter text
Year of diagnosis: *(if known)*	Click here to enter text		
Other existing medical condition(s): *(e.g. cancer, diabetes, heart-related illness, hyperlipidaemia, hypertension, kidney disease, stroke)*	Click here to enter text		
Current medication list: *(please specify)*	Click here to enter text		
Healthcare provider(s):	☐ *Hospital* *Name of Hospital:* Click here to enter text *Name of Doctor (if known):* Click here to enter text ☐ *Polyclinic* *Name of Polyclinic:* Click here to enter text *Name of Doctor (if known):* Click here to enter text ☐ *Private GP* *Name of Clinic:* Click here to enter text *Name of Doctor (if known):* Click here to enter text ☐ *Others (please specify):* Click here to enter text		

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Risk concern(s):	☐ *Suicide risk*	☐ *Family violence / elder abuse*	☐ *Fall risk*
	☐ *Physically aggressive*	☐ *Violent*	☐ *None*

Please elaborate in detail (if any):
Click here to enter text

SECTION 7: FORMAL SOCIAL SERVICE AGENCIES

Please indicate which social service agencies client is currently known to, if any:

☐ *Social Service Office*	*Please specify:* *Click here to enter text*
☐ *Family Service Centre*	*Please specify:* *Click here to enter text*
☐ *Senior Activity Centre / Active Ageing Centre*	*Please specify:* *Click here to enter text*
☐ *Meals on Wheels*	*Please specify:* *Click here to enter text*
☐ *Befriender service*	*Please specify:* *Click here to enter text*
☐ *Day Centre / Day Care*	*Please specify:* *Click here to enter text*
☐ *MSF Adult Protection Service*	*Please specify worker's name:* *Click here to enter text*
☐ *Medical Escort Services*	*Please specify:* *Click here to enter text*
☐ *Home Care Services*	*Please specify:* *Click here to enter text*
☐ *Others (please specify):* *Click here to enter text*	

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SECTION 8: ANY OTHER INFORMATION *(genogram, social report, medical report etc.)*
Click here to enter text or insert images

OFFICIAL USE ONLY *To be filled by programme administrator*
Case assigned to: *Click here to enter text*
Date assigned on: *Click here to select date*
Case reference number: *Click here to enter text*
Type of referral source: ☐ *Self/caregiver referral* ☐ *Screening* ☐ *Internal referral* ☐ *External referral*