ST. JOHN'S HOME FOR ELDERLY PERSONS

INFORMATION FOR APPLICANTS AND SPONSORS (ON RESPITE CARE ADMISSION PROCEDURES)

Name of applicant: _____

Approximate duration of stay: _____days

Date of admission: _____(Subjected to availability)

CRITERIA FOR APPLICATION:

1. Applicants should be at least 60 years old. (Those between 50 and 60 may apply to be considered on a case-to-case basis).
2. They should be reasonably well, ambulant and independent (grooming, toileting, eating, etc).
3. Having TWO Sponsors who are residing and working in Singapore.

APPLICATION FORM

1. Complete the Admission Application Form of Shelter Homes, including the Medical Report (Section C of the form, to be completed by a doctor). Various reports/attachments required as stated in the form are to be provided.
2. Complete the Resident Assessment Form (RAF, to be completed by a doctor).
3. Complete the Sponsors forms (appended to this document), one for each sponsor, duly signed.

Mandatory supporting documents to be submitted with completed application form:

1. Photocopy IC of both Sponsors and applicant (front & back).
2. Chest X-ray Report.
3. Covid Vaccination Record.
4. Medical record accompanied by a doctor's memo certifying applicant's suitability for communal living.

Page 2 - 5 to be completed by Sponsor/applicant, page 6-11 by Healthcare Professionals.

INTERVIEW

1. The Sponsors will be notified upon the consideration of their application for admission.
2. Should the applicant meet the application criteria, an interview will be scheduled.
3. The presence of both Sponsors at the interview, alongside the applicant, is a mandatory requirement.

FEES

1. A non-refundable fee of $100 before GST will be payable for each application.
2. The charge of $100 per day before GST includes accommodation, meals, laundry, physiotherapy services, programmes / activities and use of facilities.
3. Successful applicants will be charged 7 days MPS (Minimum Period of Stay) even if the actual days of stay consumed are fewer than MPS.
4. The total charges are payable in full upon admission.

Name of Applicant:		
Sponsor form 1 ☐	Sponsor form 2 ☐	
PDPA (Applicant) ☐	PDPA (Sponsor) ☐	
Sec A ☐	Sec B ☐	Sec C ☐
ERAF ☐	X-ray ☐	CVac Cert ☐
Sp 1 IC ☐	Sp 2 IC ☐	Applicant IC ☐
Medical Team's Recommendation: ✓ / ✗		
For Official Use Only	Signature:	

ST. JOHN'S HOME FOR ELDERLY PERSONS

PARTICULARS OF SPONSOR & GUARANTOR (1)

For Applicant: _____

1. Name of Sponsor: _____

2. NRIC No: _____ Age : _____

3. Address : _____

4. Telephone No. (mobile): _____ Telephone No. (home): _____

5. E-Mail : _____

6. Relationship to Applicant : _____

7. Occupation : _____

8. Employer : _____

9. Address (employer) :_____

10. Telephone No. (office) : _____Total Monthly Income: _____

11. Reasons why you cannot accommodate the Applicant?

_____

_____

I certify that the particulars stated in this form are true, correct and complete.

I fully understand and agree that the personal information which I have provided may be disclosed to other agencies or individuals for the purposes as stated below. I trust that the information will strictly be used for the purposes stated.

a. Evaluation of the client's suitability for social services or administering of social services to the applicant.
b. Provision of care services (including but not limited to medical care, physiotherapy and counselling), to the client.
c. As required by government agencies.

I agree for St. John's Home For Elderly Persons to contact me for any other purposes related to the services the Home is providing or had provided for my charge and/or on matters which I have ongoing relationship with the Home.

Signature of Sponsor: _____ Signature of Home Staff: _____

Date: _____ Name: _____

NRIC of Staff: _____ Date: _____

Maintenance Agreement/Statutory Declaration attached (to be completed only when application is approved)

ST. JOHN'S HOME FOR ELDERLY PERSONS

PARTICULARS OF SPONSOR & GUARANTOR (2)

For Applicant: _____

1. Name of Sponsor: _____

2. NRIC No: _____ Age : _____

3. Address : _____

4. Telephone No. (mobile): _____ Telephone No. (home): _____

5. E-Mail : _____

6. Relationship to Applicant : _____

7. Occupation : _____

8. Employer : _____

9. Address (employer) :_____

10. Telephone No. (office) : _____Total Monthly Income: _____

11. Reasons why you cannot accommodate the Applicant?

_____

_____

I certify that the particulars stated in this form are true, correct and complete.

I fully understand and agree that the personal information which I have provided may be disclosed to other agencies or individuals for the purposes as stated below. I trust that the information will strictly be used for the purposes stated.

a. Evaluation of the client's suitability for social services or administering of social services to the applicant.
b. Provision of care services (including but not limited to medical care, physiotherapy and counselling), to the client.
c. As required by government agencies.

I agree for St. John's Home For Elderly Persons to contact me for any other purposes related to the services the Home is providing or had provided for my charge and/or on matters which I have ongoing relationship with the Home.

Signature of Sponsor: _____ Signature of Home Staff: _____

Date: _____ Name: _____

NRIC of Staff: _____ Date: _____

Maintenance Agreement/Statutory Declaration attached (to be completed only when application is approved)

Consent for Collection and Use and/or Disclosure of Personal Data by Client

* The following information has been translated in _____ (specify language) to me by

_____ Name of staff, Designation) on _____ (dd/mm/yy).

* delete if not applicable.

I fully understand and agree that the personal information which I have provided may be disclosed to other agencies or individuals for the purposes as stated below. I trust that the information will strictly be used for the purposes stated.

a. Evaluation of my suitability for social services or administering of social services to the applicant.
b. Provision of care services (including but not limited to medical care, physiotherapy and counselling).
c. As required by government agencies.

I agree for St. John's Home For Elderly Persons to contact me for any other purposes related to the services the Home is providing or had provided me with and/or on matters which I have ongoing relationship with the Home.

Name of Client: _____ NRIC _____

Signature/Thump Print: _____ Signature of Home Staff: _____
of Client

Date: _____ Name: _____

NRIC of Staff: _____ Date: _____

To: The General Manager
St. John's Home For Eldelry Persons

Consent for Collection and Use and/or Disclosure of Personal Data by Authorised Persons

I, _____, NRIC _____ agree to allow St. John's Home For Elderly Persons to contact me for purposes related to the services the Home is providing or had provided to _____ (resident's name), NRIC _____ and/or on matters which I have ongoing relationship with the Home.

I fully understand and agree that the personal information which I have provided may be disclosed to other agencies or individuals for the purposes as stated below. I trust that the information will strictly be used for the purposes stated.

a. Provision of care services (including but not limited to medical care, physiotherapy and counselling), to the client.
b. As required by government agencies.

Signature/Thump Print: _____ Signature of Home Staff: _____

Date: _____ Name: _____

NRIC of Staff: _____ Date: _____

Pages Onwards Are To Be Completed By Healthcare Professionals.

Date of Referral: _____ **Referral Agency:** _____

Referral Staff: _____ **Contact/Email/Fax:** _____

ADMISSION APPLICATION FORM OF SHELTERED HOMES

(Sections A, B and C are to be completed by Referral Agency.)

GENERAL ADMISSION CRITERIA *(Please call the Home to clarify, if necessary.)*

- Client has given consent for this referral to be made.
- Age of client: 50-59 years old (*subject to MCYS approval, on a case-by-case basis*)
- Age of client: ≥ 60 years old
- Client is a Singapore Citizen or Permanent Resident.
- Client is ADL-independent (RAF score ≤ 15).
- Client is certified medically fit for Communal Living (*e.g. those with psychiatric condition*).
- Client's recent social report, medical report, RAF and Chest X-ray report are attached*.

*(*Without these documents, the Home is unable to assess the client's eligibility for admission.)*

SECTION A - CLIENT'S PARTICULARS & CARE STATUS *(to be provided by Referral Staff)*

Name (in NRIC) : _____

_____ (A.K.A.: _____)

NRIC No. : _____ **(Pink / Blue)**

Date of Birth (dd/mm/yyyy): _____ **Age:** ___

Address (in NRIC): _____

_____

Last Known Living Arrangement
(*Please tick the relevant boxes*):

☐ Alone ☐ With spouse ☐ With parent ☐ With sibling
☐ With child/grandchild ☐ With relative
☐ With friend ☐ In Institution ☐ Others:_____

Race: ☐ Chinese ☐ Malay ☐ Indian
☐ Eurasian ☐ Others:_____

Gender: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married
☐ Separated ☐ Divorced ☐ Widowed

Preferred Language/Dialect:
☐ English ☐ Mandarin ☐ Malay
☐ Tamil ☐ Cantonese ☐ Hokkien
☐ Teochew ☐ Hainanese
☐ Others: _____

Religion: ☐ Buddhism ☐ Taoism
☐ Christianity ☐ Catholicism ☐ Islam
☐ Hinduism ☐ Others: _____

Reason(s) that placement to Sheltered Home is client's preferred option

(*Please tick the relevant boxes*)

☐ Client's rental flat was repossessed by HDB.
☐ Client sold his/her only flat away, and is unable to buy another flat.
☐ Client is placed under HDB's waiting list for rental flat.
☐ All the family members of client (e.g. children) refuse to provide accommodation.
☐ Client refuses to live with his/ her family member, although this option is available.
☐ Client has behavioural or physical issues, which are beyond the carer's ability to cope.
☐ Client is unable to self-maintain and is deemed not suitable to live alone.
☐ Client was under abuse or neglect by family member(s).
☐ Client has exhausted his/ her savings.
☐ Client has exhausted social resources to cope with independent living (deemed by Referral Agency).
☐ None of the above. (To elaborate in social report; Brief reason: _____
_____)

Next-of-Kin/Guarantor# will attend interview with client: ☐ Yes ☐ No

Next-of-Kin/Guarantor# will support client financially for the stay in this Home: ☐ Yes ☐ No

Name of NOK/ Guarantor: _____
NRIC : _____ (Pink / Blue)
Relationship with client: _____ Age: _____
Contact numbers : _____ (HP) _____(O)
Current address : _____
_____

Brief note on this NOK/ Guarantor:
_____
_____
_____
_____

#*Note: St John's Home For Elderly Persons requires **TWO** sponsors/ guarantors. Please reflect this in Genogram. If client is on P.A., please verify with the Home if it is possible for guarantor to be a non-familial person.*

SECTION B – SOCIAL REPORT *(to be provided by Referral Staff)*

List of Required documents (*please tick if applicable and document is attached*):

☐ Copy of NRIC (Client) ☐ Copy of NRIC (NOK/Guarantor) ☐ CPF statement (Client)
☐ Copy of P.A. Card ☐ Copy of LPA ☐ Copy of MFEC ☐ Bank statement
☐ NOK/Guarantor's proof of monthly income (may require self-declaration for means-testing)
☐ Copy of Means-Test Declaration Form

Genogram (*to reflect Client's last-known living arrangement)*

Age	Names of Family Members & Guarantors	Relationship with Client	Contact	Monthly Income	Occupation

Description of Client's Relationship with Family:

Client's Means of Subsistence:
(*Please tick the relevant boxes*)

☐ Work: $ _____ (per day) or $ _____ (per month); Type of Work: _____
☐ Personal Savings : $ _____ (total estimate)
☐ Insurance / Annuity Payout : $ _____ (per month)
☐ Support from Friend / Family Member / Relative*: $ _____ (per day) or $ _____ (per month)
☐ Claim maintenance via the Tribunal (pending/finalised/defaulted*): $ _____ (per month)
☐ Public Assistance Scheme (PA Card no._____)
☐ Welfare grant (CDC) : $ _____ (per month) for _____ months
☐ Social Service Agency : $ _____ (per month) for _____ months
☐ Religious organisations : $ _____ (per month) for _____ months

*Please delete as appropriate.

Additional notes on family's situation (e.g. financial):_____

_____

All the information provided in Sections A and B is true and accurate.	Verified by: _____ NOK / Guarantor or Client	Witnessed by: _____ Name of Staff: Date:

SECTION C – MEDICAL REPORT (*to be endorsed / signed by a Medical Doctor*)

Client's medical report, RAF, and Chest X-ray report should be attached to this application.
Without these documents, the Home *is unable to assess* the client's eligibility for admission.

Name of Patient: _____ NRIC: _____

Primary Diagnosis & Clinical Findings:

Other Significant Medical History/ Secondary Diagnosis:

☐ Diabetes Mellitus ☐ Hypertension ☐ High Blood Pressure ☐ HIV ☐ CVA/Stroke ☐ IHD
☐ MRSA colonised/infective ☐ Tuberculosis ☐ Dementia (*Please attach Psychiatrist's report*)
Others (*e.g. psychiatric conditions, skin conditions*), please specify: _____

_____

Is patient suffering from any infectious disease? ☐ **No** ☐ **Yes, if specify:** _____

Psychological & Behavioural Condition (*please tick the relevant boxes for **ALL** listed items*):

Agitation &/or Aggression : ☐ N.A. ☐ Occasionally ☐ Frequent ☐ Always
Violence : ☐ N.A. ☐ May self-inflict ☐ Verbally Abusive ☐ Physically Abusive ☐ Has suicidal ideation
Bed Restraint : ☐ N.A. ☐ Required temporarily ☐ Required occasionally ☐ Required permanently
Sleep / Disruption: ☐ Able to sleep ☐ Relies on sleeping pills ☐ Required sedation ☐ Chronic sleep issues

Summary of Nursing & Rehab Needs (*please tick the relevant boxes for **ALL** listed items*):

Feeding & Dietary : ☐ N.A. ☐ Special diet ☐ Ryle's tube ☐ PEG ☐ Flexiflo
Respiratory & Cardiovascular : ☐ N.A. ☐ O2 Therapy ☐ BiPAP Machine
Stoma / Gastro-intestinal : ☐ N.A. ☐ Colostomy ☐ Tracheotomy Care ☐ Illeostomy
Urinary Tract : ☐ N.A. ☐ Intermittent Cath. ☐ Supra-pubic Cath. ☐ Urethra
Kidney / Renal : ☐ N.A. ☐ Kidney/Renal Care (*with medication*) ☐ Hemodialysis
Wound Care : ☐ N.A. ☐ Prone to bedsores ☐ Minor/infrequent ☐ Intensive/frequent
Client has impairment(s) which affect verbal communication: ☐ N.A. ☐ Sight ☐ Speech ☐ Hearing
Doctor's report on chest X-Ray: _____
Other medical condition, please specify: _____
Client is certified to be fit for light exercise : ☐ Yes ☐ No
Client is certified to be fit for communal living : ☐ Yes ☐ No
Client is recommended for Physical Medicine & Rehabilitation (PM&R)# : ☐ Yes ☐ No

#*Previous rehabilitation/treatment plan by PT or OT needs to be furnished for reference.*

List of Current Medications*:
Any drug allergy / other allergy: ☐ No ☐ Yes, please specify:

1.	**5.**
2.	**6.**
3.	**7.**
4.	**8.**

**Please attach photocopies of patient's appointment cards to ensure medical appointments are tracked.*

Endorsed/ Signed by : _____ Date: _____
Name of Doctor (Dr) : _____
Designation/Dept/Institution : _____

FOR USE BY SHELTERED HOMES ONLY

SECTION D – RESPONSE SLIP (*Home Staff to email/fax to Referral Staff within 5 working days from the date when referral was received*)

Date : _____

Fax / Email of Referral Officer : _____

Name of Referral Staff : _____

Designation/Dept/Institution : _____

Intermediate Outcome of Application:

☐ Client is eligible for admission to my Sheltered Home at this stage (*application form is complete, recommended for interview & final approval*)

☐ Client is unsuitable for admission (*application is rejected, please note reasons below*)

☐ Application form is incomplete, please *refurnish* information for Section A / B / C*.

☐ Missing document(s) to be furnished: _____

**Please circle accordingly*

Signed by (Home Staff) : _____ Date: _____

Name of Home Staff : _____

Designation / Agency : _____

Contact / Email / Fax : _____

SECTION E – OUTCOME OF REFERRAL (*Home Staff to email/fax to Referral Staff within 10 working days from the date when Section D was emailed/faxed to Referral Agency*)

Final Decision of Admission Committee: ☐ Rejected[1] ☐ Pending[2] ☐ Approved[3]

Fee Payable (monthly) : $_____ / FOC *(please delete accordingly)*

Date / Time of Meeting : _____

Signature by Approving Officer : _____

Name of Approving Officer : _____

Reasons (for rejected application) : _____

_____

_____

[1]*The Home Staff can reject the application based solely on the information provided in the admission form and documents at the intermediate stage of application. Rejected application will not be processed by the Admission Committee. The Home Staff shall refer these applicants to alternative options.*

[2]*If the case is pending approval, please update the Referral Staff (email/fax/call) regarding this status and inform them about the date of meeting by the Admission Committee.*

[3]*After an approval is given, NOK/ Guarantor(s) is/ are required by the Home to sign a declaration form (Undertaking for Admission). The Referral Staff shall educate NOK/ Guarantor(s) about this procedure and their obligations. The approval status may be affected if they fail to sign this form. This form can be obtained from respective Homes.*

Client has passed the means test : ☐ N.A. ☐ Yes ☐ No

Client will enjoy subsidies (*if applicable*) at : MCYS[#] 75%/ 60%/ 50%/ 40%/ 20% (SC)

MCYS[#] 50%/ 40%/ 30%/ 20%/ 0% (PR)

NCSS 10% (SC & PR)

[#]*The Sheltered Homes with MCYS funding are AWWA Community Home for Senior Citizens, PERTAPIS Senior Citizen Fellowship Home, Evergreen Place Home@Hong San and Geylang East Home for the Aged.*

IMPORTANT NOTE: *This Admission Application Form is developed by the National Council of Social Service, in consultation with the Sheltered Homes and MCYS. Please contact NCSS for any further enquiry.*

Version: Dec 2019

ENHANCED RESIDENT ASSESSMENT FORM (ERAF)

Name: IC/FIN Number:

Date of Birth: Age (years): Sex (M/F)

Paste ID Label here

RAF	Score (please circle) with Description for Each Score			
Q1 – Mobility (and Transfer)	- Refers to a resident's ability to move from one point to another and includes transfer - **Excludes** supervision of a wandering or mentally disturbed resident (included in Behavioural Problems Q9)			
	A	**B**	**C**	**D**
	0 points	**3 points**	**10 points**	**16 points**
	Independent	**Requires some assistance (physical/assistive device)**	**Requires frequent assistance/turning in bed**	**Requires total physical assistance**
	- Includes walking aid/wheelchair independent residents - Requires no assistance in mobilizing and transfer (whether walking or using a walking aid/wheelchair)	- Needs some supervision, prompting, assistance or instructions to move around and/or transfer - Needs some supervision and physical guidance by staff in walking / use of assistive devices e.g walking frame, quad stick	- Requires frequent supervision, prompting or physical assistance by staff in walking / use of assistive devices e.g walking frame, quad stick - Requires pushing of wheelchair and/or transfer/turning in bed	- Needs total assistance in positioning, transfer and turning of residents who are chair bound or bed-ridden
	Remarks:			
Q2 – Feeding	- **Excludes** preparation of food in kitchen and dishing out and serving of food - **Excludes** pushing and/or positioning of wheelchair at the dining table (included in Mobility Q1) - **Excludes** insertion and maintenance of nasogastric tubes (included in Treatment Q5 under "special procedures")			
	A	**B**	**C**	**D**
	0 points	**3 points**	**10 points**	**10 points**
	Independent	**Requires some assistance**	**Requires total assistance**	**Tube feeding**
	- Able to eat without prompting, supervision or assistance - May need reminders for meal times	- Requires some supervision/assistance with feeding. For e.g. constant prompting, positioning of residents for meal times, further cutting up of food, cleaning up after meal times due to poor and messy eating - Requires general or group supervision/assistance due to dysphagia (difficulty swallowing) or risk of choking	- Requires total supervision/assistance with feeding (due to dysphagia (difficulty swallowing), risk of choking, and/or poor or messy eating) - Requires one-to-one supervision/assistance for feeding	- Includes preparation of feeds and any assistance of tube feeding by staff
	Remarks:			
Q3 – Toileting	- **Excludes** assisting residents when getting on a wheelchair and pushing to toilet (included in Mobility Q1) - **Excludes** care and/or emptying/draining of colostomies or catheters (included in Treatment Q5 under "special procedures")			
	A	**B**	**C**	**D**
	0 points	**3 points**	**8 points**	**16 points**
	Independent	**Requires some physical assistance**	**Requires commode/bedpan/urinal**	**Incontinent and totally dependent**
	- Able to conduct all toileting activities without assistance	- Needs minimal assistance/supervision with undressing and dressing, clothing adjustments, positioning over toilet bowl/commode/bedpan/urinal, or change of clothes/diapers (including pull-up diapers)/bedding	- Needs supervision/assistance **throughout** toileting - Needs moderate supervision/assistance to position over toilet bowl/commode/bedpan/urinal, or for diaper change	- Needs cleaning after episodes of incontinence of urine or faeces - Needs total and frequent assistance in the use of commode/bedpan/urinal/ or diaper change
	Remarks:			
Q4 - Personal Grooming and Hygiene	- Activities include: Bathing: including soaping, washing, drying Dressing: selection of appropriate clothing, putting on slippers, maintaining neat attire Using devices: fitting of artificial limbs, calipers, supporting stockings, slings and splints; cleaning and fitting of hearing aids; spectacle care Oral care: brushing teeth, cleaning and fitting of dentures Grooming: combing of hair, trimming of fingernails and toenails, shaving Personal hygiene: handling sanitary napkins - **Excludes** changes of clothing and cleaning after episodes of incontinence (included in Toileting Q3) - **Excludes** changes of clothing after episodes of colostomy or catheter leakage (included in Treatment Q5 under "special procedures")			
	A	**B**	**C**	**D**
	0 points	**2 points**	**4 points**	**6 points**
	Requires no assistance	**Requires assistance for some activities/supervision**	**Requires assistance for all activities**	**Bed/trolley bathing**
			- Needs constant and repeated prompting, reminding or assistance throughout activities	- Total care of all activities of daily living (includes residents who may be bathed on commode, requiring total assistance for all activities)
	Remarks:			

Q5 - Treatment (daily medication)

A	B	C	D
___ points	**___ points**	**___ points**	**___ points**
- Oral or topical medication: **1 point**	- Oral or topical medication: **1 point** - Injection[2]: **2 points**	- Oral or topical medication: **1 point** - Injection[2]: **2 points** - Physiotherapy or occupational therapy: **4 points**	- Oral or topical medication: **1 point** - Injection[2]: **2 points** - Physiotherapy or occupational therapy: **4 points** - Special procedures[1] **(1 point per 5 minutes needed to perform procedure)**

[1] Special procedures include (NOT limited to): catheter **care/draining** of bag, colostomy care/emptying of bag, blood glucose monitoring, urinalysis, wound dressing, oxygen administration, nebulizer, tracheostomy care, feeding tube care, peritoneal dialysis
[2] **Excludes** injections which are PRN or administered at an external facility
- **Excludes setting up trays** or collecting **equipment** for use in **procedures**

Remarks:

Q6 - Social and Emotional Needs

Includes:
- Encouragement to participate in recreational and social activities
- Support to families of residents who may be anxious and upset, including building relationships with them, encouraging them to visit and making them feel welcome
- Intervention to help residents adjust to the routines of the nursing home
- Counselling and interaction of residents to cope with emotional distress

A	B	C	D
0 points	**1 points**	**2 points**	**3 points**
Nil	**Occasionally (1-3 times a week)**	**Often (4-6 times a week)**	**Always (daily)**

Remarks:

Q7 - Confusion (loses things, loses way, disorientated)

Includes:
- Dealing with confusion, disorientation and poor memory
- Determining how well a resident is orientated in time, place and person
- Determining resident's ability to recall remote, recent, past, immediate events
- Managing episodes when resident loses his possessions, loses his way, etc
- **Excludes** routine activity programmes or prompting to continue an activity
- **Excludes** any increased assistance and attention required during initial settling-in period (included in Social and Emotional Needs Q6)

A	B	C	D
0 points	**3 points**	**8 points**	**10 points**
Nil	**Occasionally (1-3 times a week)**	**Often (4-6 times a week)**	**Always (daily)**

Remarks:

Q8 - Psychiatric Problems

- Scoring is based on how **psychiatric symptoms*** interfere with existing ability to perform activities of daily living (ADLs) **based on the most recent period observed**
***Psychiatric symptoms include:** hallucinations, delusions, lack of interest/engagement in goal-directed behaviour, prolonged low mood, pessimistic thoughts, apprehension, uneasiness
- Conditions e.g. anxiety, depression. A confirmed psychiatric diagnosis is not necessary, however there must be documentation by a healthcare professional that the resident exhibits psychiatric symptoms

Includes:
- Early identification of symptoms of relapses for management
- Counselling of anxious and depressed residents
- Dealing with situations that arise as a result of the disruptive behavior of resident due to hallucinations / delusions
- **Excludes** adjustment problems

A	B	C	D
0 points	**2 points**	**4 points**	**6 points**
Nil	**Mild interference in life**	**Moderate interference in life**	**Severe interference in life**
	Psychiatric symptoms* interfere with existing ability to perform ADLs and/or social/recreational activities around 25% of the time	Psychiatric symptoms* interfere with existing ability to perform ADLs and/or social/recreational activities around 50% of the time	Psychiatric symptoms* interfere with existing ability to perform ADLs and/or social/recreational activities around 75% of the time

Remarks:

Q9 - Behavioural Problems

- Refers to the frequency and severity of behaviour(s) displayed by the resident **based on the most recent period observed**
- Includes (NOT limited to): physical aggression, verbal disruption, agitation, restlessness, non-compliance to instructions, manipulation, self-destructiveness, sexual disinhibition (repeated stripping of clothes and/or diapers, molestation), wandering, absconding, food-grabbing, hoarding, suicidal ideation and/or attempts, repetitive behaviour (e.g excessive water drinking and washing of hands) and sensory seeking behaviour (e.g playing with water and/or faeces, self-scratching)
- **Excludes** assistance and attention given to residents during their initial settling-in period (included in Social and Emotional Needs Q6)

A	B	C	D
0 points	**3 points**	**10 points**	**16 points**
Nil	**Occasionally (1-3 times a week)**	**Often (4-6 times a week)**	**Always (daily)**
	Frequency may not be as stated above, but the behaviour is of low severity and manageable	Frequency may not be as stated above, but the behaviour is of moderate severity and manageable	Frequency may be often or always, but the behaviour is severe and difficult to manage.

Remarks:

Total Points: Category **(please circle):** I II III IV

Category I: ≤ 6 points, Category II: 7-24 points, Category III: 25-48 points, Category IV: >48 points

Name of Staff Completing RAF: Designation: Organisation:

Signature: Date: