CLARITY SINGAPORE LIMITED
REFERRAL FORM

Please email referral@clarity-singapore.org or call **67577990 or 97103733** to:

i) Inform Clarity about the new referral.
ii) Arrange the requested appointment for the client with our Appointment Desk.

Date of referral:			
Required service:			
Counseling / psychotherapy / support group / other mental health services*			
*Please specify:			
Referrer details (your details)**:**			
Name / Designation:			
Institution / Department:			
Office Address:			
Office / Mobile no:		Email:	
Client details:			
Name:		Gender:	
Language spoken:		Date of Birth:	
Home / Mobile no.:		Email:	
Address:			
Diagnosis (if any) by attending doctor:			
Medication (if any):			
Name of Attending Doctor (if any):		Email / Tel no.:	

Reasons for Referral: (please include presentation, history, risk factors/ alerts)

Additional Information: (May include patient's other medical issues, financial means, family details, etc.)

Personal Data Protection Act (PDPA) compliance:
If you are a 'public agency' within the meaning of the PDPA, please proceed to send this referral to Clarity for the purpose of Clarity providing its services to the patient. Otherwise, by signing below you certify that the referred has provided you with (a) their consent to disclose personal data about them that is included in this referral form for the purpose of Clarity providing its services to the referred and (b) if Clarity is unable to provide the appropriate services deemed necessary, their consent to Clarity exploring and putting into place further referral(s) as Clarity may consider reasonably necessary or desirable for the benefit of the referred.

Signature:			
Referrer's signature:		Organisation stamp:	

Clarity's official use:			
Therapist:		Date of 1st appointment:	