Tan Tock Seng
HOSPITAL

APPLICATION FORM FOR NEW TETRAPLEGIC

TETRAPLEGIA WORKGROUP
c/o Dept of Rehabilitation Medicine, TTSH
Ang Mo Kio Community Hospital
17 Ang Mo Kio Ave 9
Singapore 569766
www.tetraplegiaworkgroup.org

Tetraplegia Workgroup

<table>
<tr><td colspan="2">NAME</td><td></td><td colspan="3">NRIC / PASSPORT NO.</td><td colspan="2"></td></tr>
<tr><td>GENDER
(M/F)</td><td></td><td>RACE
(C/M/I/Other)</td><td></td><td colspan="2">DATE OF BIRTH
(YYYY/MM/DD)</td><td colspan="2"></td></tr>
<tr><td colspan="2">ADDRESS</td><td></td><td colspan="3">DATE OF INJURY
(YYYY/MM/DD)</td><td colspan="2"></td></tr>
<tr><td colspan="2">ZONE
(Nor/East/Central)</td><td></td><td colspan="3">LIFT LANDING FLAT
(Yes/No)</td><td colspan="2"></td></tr>
<tr><td colspan="2">TELEPHONE</td><td></td><td colspan="3">HANDPHONE/ PAGER</td><td colspan="2"></td></tr>
<tr><td colspan="2">E-MAIL</td><td></td><td colspan="3">MARITAL STATUS</td><td colspan="2"></td></tr>
<tr><td colspan="2">MAIN DIAGNOSIS / LEVEL OF INJURY</td><td colspan="6"></td></tr>
<tr><td colspan="3">FOLLOW UP
(eg TTSH rehab, NUH, OPS etc)</td><td colspan="2"></td><td colspan="2">LANGUAGE SPOKEN</td><td></td></tr>
<tr><td colspan="3">FEEDING
(Indept, Assist, Total dept)</td><td colspan="2"></td><td colspan="2">HAS ELECTRIC WHEELCHAIR
(Y/N)</td><td></td></tr>
<tr><td colspan="3">HOME VISIT REQUIRED
(Y/N)</td><td colspan="2"></td><td colspan="2">FREQUENCY OF HOME VISITS ?</td><td></td></tr>
<tr><td colspan="3">MAIN NEEDS OF PATIENT
(WRITE AS MUCH AS POSSIBLE)
Include: medical, therapy, transport, social, nursing, financial, employment, others</td><td colspan="5"></td></tr>
<tr><td colspan="3">NOTES PATIENT CHARACTERISTICS
Include things like very depressed patient, very gung ho patient, loves to volunteer etc and anything else</td><td colspan="5">.</td></tr>
<tr><td colspan="3">NAME OF TW VOLUNTEER OR MEMBER ASSIGNED</td><td colspan="5"></td></tr>
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When completed, please fax to 6459-0414 attn: Dr.Adela Tow

*Or email to **Adela_Tow@ttsh.com.sg** as an attachment*