|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **Referral Form for** | | | | | | **Appendix 4** |  |
|  |  |  |  |
|  | **Integrated Community Centre for Mental Wellness (ICCMW)** | | | | | | | |  |
|  |  |  | | | | | |  |  |
| *From :* | Officer-in-Charge |  |  |  |  |  | *To :* | Officer-in-Charge |  |
|  |  | | | |  |  |  | ICCMW |  |
| *Ref. :* |  | | | |  |  | *Ref. :* |  |  |
| *Tel No. :* |  | | | |  |  | *Dated :* |  |  |
| *Fax. No. :* |  | | | |  |  | *Fax. No. :* |  |  |
| *Date :* |  | | | |  |  | *Total Page(s) :* |  |  |
|  |  |  |  |  |  |  |  |  |  |

**Referral for ICCMW**

**from \*Welfare Services Unit / Medical Social Services Unit /**

**Psychiatric Service of Hospital Authority (HA) / Community Psychiatric Services (CPS) / Personalised Care Programme (PCP) of HA**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Name : |  | Sex / Age: |  | Date of Birth: |  |
| Address : |  | | | | |

I refer to the telephone discussion between (Name of referrer) of our Centre and (Name of ICCMW’s worker) of your ICCMW on \_\_\_\_\_\_\_\_\_\_\_\_\_ and would like to refer the above-named for your services for \*his / her \*mental health / suspected mental health problem.

2. To facilitate your follow-up action, the following information is provided:

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **(I) Particulars of Applicant** | | | | | | | | | | | | | | | |
| Name : (English) |  | | | | | | | (Chinese) | | | |  | | | |
| Tel. No. : (Home) |  | | | | | | | (Mobile) | | | |  | | | |
| HKIC No. : |  | | | | | | |  | | | |  | | | |
|  |  | | | | | | |  | | | |  | | | |
| Service(s) required from ICCMW : | | | | Counselling | | | Groups and Programmes  Skill training | | | | | | | | |
|  | | | | Case management | | | | | | Carer support | | | | | |
|  | | | | Peer support service  Clinical psychological service | | | | | | | | | | | |
|  | | | | Services for children of Persons in Mental Recovery | | | | | | | | | | | |
|  | | | | Others:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | |
| \*Diagnosis / Suspected mental health problem (if any) : | | | | | | | | |  | | | | | | |
| Date of onset (if any): | | |  | | | | | | | | | | | | |
| Psychiatric Follow-up Clinic (if any): | | | | |  | | | | | | | | | | |
| Special Remarks: | | Conditional Discharge | | | | Intensive Care | | | | | | | Ex-intensive Care | | |
|  | | Special Care | | | | Conventional Care | | | | | | |  | | |
| Contact Points of Case Manager of \*CPS/PCP (if any) : | | | | | | Name : | | | | |  | | | Tel. No. : |  |
| Other support services (e.g. MSSU, POT, IFSC, etc.) : | | | | | | | |  | | | | | | | |

Details of any emotional, psychological or behavioral problems that warrant special attention, including but not limited to suicidal attempt / suicidal tendency and violence / violence tendency (if any) :

|  |
| --- |
|  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Rehabilitation service(s) waitlisted: | Supported Employment | | | Sheltered Workshop | |
|  | Residential Service (please specify) : | | | |  |
|  | Others : |  | | | |
|  | Not known | |  | | |

Consent of applicant

\*has been / has not been obtained for receiving ICCMW services;

\*has been / has not been obtained that ICCMW’s worker can approach the case medical officer / paramedical staff / social workers concerned for information regarding the provision of ICCMW services.

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **(II) Information of Applicant’s Family Member / Carer** | | | | | | | | | | | | | |
| Name : | Mr./Mrs./Ms. | | ( | | | ) | | Tel. No. : | | |  | |
|  | *(English)* | | | | *(Chinese)* | |  | |  | | |  | |
|  |  | | | |  | |  | | | | | | |
| Living with the applicant : \*Yes / No | |  | | Relationship with applicant : | | | | | |  | | | |

Consent of the family member / carer \*has been / has not been obtained that ICCMW’s professional workers can approach \*him / her if necessary.

|  |  |
| --- | --- |
| **(III) Referral Summary and Special Remarks (Use additional sheet if required)** | |
|  |

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **(IV) Information of Referring Office** | | | | | | | | | | |
| Name of Referrer : | | | | |  | | Post : |  | Tel. No. : |  |
| Agency : |  | | | | | | | | Fax No. : |  |
| Office Address : | | | |  | | | | | | |
|  | | | |  | | | | | | |
| Remarks : | |  | Our Centre will continue to follow-up the welfare needs of the applicant / applicant’s family. Please issue the Service Admission Form to our unit within 8 weeks upon the receipt of the referral. | | | | | | | |
|  | |  | No follow-up action will be taken by our Centre since the applicant / applicant’s family has no other immediate and / or long term welfare needs at our Centre. | | | | | | | |
|  | |  | Others (please specify) : | | |  | | | | |

3. Please acknowledge receipt of this referral **within seven working days** from the date of this referral. For enquiries, please contact at .

|  |  |
| --- | --- |
|  | ( ) |
|  | *Officer-in-Charge* |
| *Name of Centre:* |  |
|  |  |
| *District:* |  |

*\*delete whichever is inappropriate*