

Baptist Oi Kwan Social Service
Mental Wellness Service for Children

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Referral Form

Form No.: SQS-0312B

Review Date : 4/2025

Service target: for children/adolescents aged **6-18** with mental health issues from **all** districts

To:	_____	From:	_____
	Baptist Oi Kwan Social Service		_____
Tel No.:	_____	Our Ref.:	_____
Fax. No.:	_____	Tel No.:	_____
Date:	_____	Fax. No.:	_____

Personal Particulars

Name	(English) _____	(Chinese) _____
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female	Place of Birth _____
Date of Birth	_____	Age _____
Contact No.(s) (Fill where applicable)	(Home) _____ (Mobile) _____ (Work) _____ (Father) Name: _____ Tel: _____ (Mother) Name: _____ Tel: _____ (Significant others) Name: _____ Relationship: _____ Tel: _____ Name: _____ Relationship: _____ Tel: _____ <input type="checkbox"/> Consent obtained to contact family/carers	
Address	_____	
School	_____	Education Level _____
Psychiatric follow up	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> First Onset <input type="checkbox"/> Defaulted since _____	
Follow-up Clinic	_____	Psychiatrist /Doctor _____

Psychiatric History (If applicable)

Diagnosis	_____		Symptoms	_____
Date of Onset	_____			
Hospitalisation	Period	Symptoms	Hospital	
	_____	_____	_____	
Current Medication	Name / Type	Dosage		
	_____	_____		

Reason(s) for referral

☐ individual support (center based)
 ☐ individual support (school based)
 ☐ social emotional groups
☐ consultation/ assessment for mental health issues
☐ others: _____

Presenting Problems

Name of Referrer : _____ **Post :** _____ **Agency :** _____

Signature of Referrer: _____ **Tel :** _____ **E-mail:** _____

Our service primarily offers psycho-education and early prevention interventions, aligning with the first tier of the Three-tier School-based Emergency Mechanism. If clinical intervention services are required, referrals will be made based on clients' needs or the assessments by social workers or counsellors.