|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  | **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*