

Community Psychiatric Service (CPS) of Hospital Authority (HA)

Receipt of Referral

(to be issued within 7 working days by CPS as from date of referral)

<i>From :</i> Office of Community Psychiatric Service (HA Cluster: _____)	<i>To :</i> Officer-in-Charge _____ ICCMW
<i>Ref. :</i> _____	<i>Ref. :</i> _____
<i>Tel No. :</i> _____	<i>Dated :</i> _____
<i>Fax. No. :</i> _____	<i>Fax. No. :</i> _____
<i>Date :</i> _____	<i>Total Page(s) :</i> _____

Receipt of Referral for CPS

Name : _____
HKIC No. : _____
Sex / Age : _____

In respect of the above referral on _____, our team

- would contact the client for a clinical assessment.
- Others (please specify) : _____

2. Should there be any enquiries, please contact _____ at _____.

(_____)
CPS / HA (_____) Cluster