Appendix 10

Referral Form for
Community Psychiatric Service of the Hospital Authority (HA)
by Integrated Community Centre for Mental Wellness (ICCMW)

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

Referral for Community Psychiatric Service (CPS) by ICCMW

Name : ________________________

Sex / Age : ________________________

Address : ________________________

____

I refer to the telephone discussion between ____________ (Name of staff) of your CPS and (Name of referrer) of our ICCMW on _________ and would like to refer the above-named for your arrangement of *clinical assessment / psychiatric treatment for *his / her *mental health / suspected mental health problem.

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

(I) Information of Applicant

Name : (English) ____________________ (Chinese) ____________________

Tel. No. : (Home) ____________________ (Mobile) ____________________

HKIC No. : ____________________

Applicant's presenting mental / suspected mental health problems :

____

____

____

Service(s) received from ICCMW :

- ☐ Counselling
- ☐ Groups and Programmes
- ☐ Skill training
- ☐ Case management
- ☐ Carer support
- ☐ Peer support service
- ☐ Clinical psychological service
- ☐ Others: ____________________

Consent of applicant

☐ *has been / has not been obtained for receiving community psychiatric services;

☐ *has been / has not been obtained that CPS' staff can approach concerned caseworkers for information regarding the provision of community psychiatric service.

(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 CPS' staff can approach *him / her if necessary.

(III) Information of Referring ICCMW

Name of Referrer : ____________ Post : ____________ Tel. No. : ____________

Agency : ____________ Fax No. : ____________

Office Address : ____________

Remarks : Apart from ICCMW, the applicant is now receiving service from :

☐ ____________ *Integrated Family Service Centre / Integrated Service Centre

☐ Family and Child Protective Services Unit (____________)

☐ Medical Social Services Unit of ____________ Hospital / Clinic

☐ Others (please specify) : ____________

3. Please acknowledge receipt of this referral **within seven working days** from the date of this referral. Should there be any enquiries, please contact ____________ at ________.

( )

Officer-in-Charge

ICCMW

**delete whichever is inappropriate*