

關愛之家

Home Care for Girls

Referral form

 for Admission to □ Tsing Yi Home(關愛之家)

 □ Shatin Hostel(延愛之家)

1. **Client Particulars**

|  |  |  |  |
| --- | --- | --- | --- |
| English Name: |  |  |  |
| Chinese Name: |  | Date of birth (Age)  |  | ( ) |
| Address: |  | HK I.D. or other Documents no. (please specify): |  |
|  |  |
| Tel/Mobile: |  |
|  |  | Year arrived in HK: |  |
| Financial Status: |  | □ Recipient of CSSA |  |
| Name of School: School Address: | (中文) | (English) |  |
| (中文) | Tel. no.: |  |
| Schooling/Occupation  | □ Primary/Secondary□ Undergraduate□ Employment |
|  |
|
|  |  |  |
| Record of previous placement, if any |
|

|  |  |  |  |
| --- | --- | --- | --- |
| Name of Residential Unit | Date of Admission | Date of Discharge | Reasons for Discharge |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

 |  |

1. **Particulars of Family Background**
2. Details of parents/guardians/relatives (**Major Contact Person**)

|  |  |  |  |
| --- | --- | --- | --- |
| English Name: |  | Sex: |  |
| Chinese Name: |  | Age: |  |
| Relationship: |  | HK ID no.: |  |
| Occupation: |  | Income: |  |
| Address:  |  |
| Tel/mobile: |  |

1. Particulars of family members & relatives **significant to the client** (*Mark “****#****” before the names to indicate those who are living apart)*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Name(In English & Chinese) | Relationship to client  | Sex | Age | Occupation/Schooling | Income |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

1. Current family relationship

|  |
| --- |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |

1. **Case Details**
2. Reasons for referral

|  |
| --- |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |

1. School history and performances

*Including behavioral, emotional, social and academic performances*

|  |
| --- |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |

1. Involvement of client and their parents/ guardians

|  |
| --- |
| * 1. *Client’s reaction of the referral*

□ Accepted readily□ Accepted with counselling□ Cannot accept but continuous counseling is required* 1. *Guardian’s reaction in the decision of out-of-home care*

□ Accepted readily□ Accepted with counseling□ Cannot accept but continuous counseling is required |

**D. Health and Mental Health Condition**

1. Current health condition
	1. *Is the client suffering from any physical or mental illnesses (e.g. Depression, ADHD, Personality disorder)?* ***Yes/ No***

*If yes, please elaborate:*

|  |
| --- |
|  |
|  |
|  |
|  |
|  |
|  |

* 1. *Is the client suffering from allergies?* ***Yes/ No***

*If yes, please specify:*

|  |
| --- |
|  |
|  |
|  |
|  |
|  |

* 1. *Is the client having any history/ideation of harming herself or any other behavioral manifestation?* ***Yes/ No***

*If yes, please elaborate:*

|  |
| --- |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |

* 1. *Details of medical follow up*

|  |  |
| --- | --- |
| Name of Clinic/ Hospital: |  |
| Name of Department: |  |
| Contact Person *(For discussion on client’s health condition, If necessary)* : |  | □Dr. □CP □CNS □MSW |
|  |
| Tel. no.: |  |

**E. Court Order/Criminal Record**

1. Is the client under any court order? **Yes/ No**

*If yes, please tick the appropriate boxes accordingly and specify the effective period*

|  |  |  |
| --- | --- | --- |
| □ Ward of DSW: |  |  |
| □ C or P Order: |  |  |
| □ Police Superintendent's Discretion Scheme: |  |  |
| □ Community Service Orders (CSO) Scheme: |  |  |
| □ Other: |  |  |
| ***( Please Attach a copy of the above said document)*** |

1. Does the client has any criminal record? **Yes /No**

*If yes, please elaborate:*

|  |
| --- |
|  |
|  |

**F. Welfare & Discharge Plan**

|  |
| --- |
|  |
|  |
|  |
|  |
|  |

**G. Particulars of Referrer**

*Please tick the appropriate boxes accordingly*

|  |  |
| --- | --- |
| Name of Referral Officer: | \* Mr./Mrs./Ms. |
| Signature : |  |
| Type of Referring Office: | □SWD | □NGO □ED □Hospital Authority  |
| Others: |  |
| Office Name:  |  |  |
| □FSC | □CPSU □CCSU □PO □MSS  |
|  | Others: |  |
| Post and Title: |  |
| Name of Agency: |  |
| Address: |  |
| Tel. No.: |  |
| Fax No.: |  |
| Date |  |
| **\* The Personal information provided serves only for application use and the data of the non-suitable client will be deleted within six months.** |