

關愛之家

Home Care for Girls

Referral form

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 |
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|  |  |  | | | | |
| 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**)

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| --- | --- | --- | --- | --- |
| 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)*

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| Name  (In English & Chinese) | Relationship to client | Sex | Age | Occupation/  Schooling | Income |
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1. Current family relationship

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

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1. School history and performances

*Including behavioral, emotional, social and academic performances*

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1. Involvement of client and their parents/ guardians

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| * 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:*

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

*If yes, please specify:*

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

*If yes, please elaborate:*

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* 1. *Details of medical follow up*

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

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| --- | --- | --- | --- | --- |
| □ 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:*

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**F. Welfare & Discharge Plan**

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**G. Particulars of Referrer**

*Please tick the appropriate boxes accordingly*

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| 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.** | | |