

**Referral Form for  
Integrated Community Centre for Mental Wellness  
(ICCMW)**

<i>From:</i> Officer-in-charge	<i>To:</i> Officer-in-charge
<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> _____

**Referral for ICCMW  
from \*Welfare Services Unit / Medical Social Services Unit /  
Psychiatric service of Hospital Authority (HA) / Personalised Care Programme of HA**

Name: \_\_\_\_\_  
Sex / Age: \_\_\_\_\_  
Address: \_\_\_\_\_

I would like to refer the above-named for your intervention services for \*his / her \*mental health / suspected mental health problem. Telephone discussion \*has been / has not been made between the referrer (*please state referrer's name if applicable: \_\_\_\_\_*) and your Centre's staff (*please state name of ICCMW's worker if applicable: \_\_\_\_\_*) prior to this referral.

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

**(I) Particulars of Applicant:**

Name: (English) \_\_\_\_\_ (Chinese) \_\_\_\_\_

Tel. No.: (Home) \_\_\_\_\_ (Mobile) \_\_\_\_\_

Service(s) required from ICCMW:    Activities    Counselling    Skill training    Carer support  
   Drop-in    Others \_\_\_\_\_

\*Diagnosis / Suspected mental health problem (if any): \_\_\_\_\_

Psychiatric Follow-up Clinic (if any): \_\_\_\_\_

Other support services (e.g. MSSU, CPS, PCP, IFSC, etc.): \_\_\_\_\_

Details of any emotional, psychological or behavioral problems that warrant special attention (if any):

Rehabilitation service(s) waitlisted:    Supported Employment                      Sheltered Workshop  
   Residential Service (please specify: \_\_\_\_\_)  
   Others \_\_\_\_\_

Consent of applicant \*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 Carer / Family member:**

Name: \_\_\_\_\_ ( \_\_\_\_\_ ) Contact means / Tel. No.: \_\_\_\_\_  
(English) (Chinese)

Living with the applicant: \*Yes / No Relationship with applicant: \_\_\_\_\_

Consent of the carer / family member \*has been / has not been obtained that ICCMW's professional workers can approach him / her in case of emergency.

**(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 above-named / above-named'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 welfare needs at our Centre. In this connection, Service Admission Form \*is / is not requested.

Others (please specify): Our centre would terminate the case upon successful referral to your centre due to client's address was out of our service boundaries.

3. Please acknowledge receipt of this referral **within seven working days** from the date of this referral. For enquiries, please contact \_\_\_\_\_ at phone no. \_\_\_\_\_.

( \_\_\_\_\_ )

Officer-in-charge

\_\_\_\_\_ *Centre*

*\*Delete whichever is inappropriate*