

**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 Service 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): _____

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

**Please select appropriate*