社會福利署
Social Welfare Department

Central Referral System for Rehabilitation Services (CRSRehab)

Forms of the Subsystems

April 2025
(Revised Edition)

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An Overview of the Forms of the Central Referral System for Rehabilitation Services

The related forms of CRSRehab have been streamlined, but for clarity, each subsystem has its own set of prefex on the forms. An overview of the forms is as below:

Form No.	From	To	Name of the form	Applicable in CRSRehab				
				IPD	PMR	VI	SGHCMID	SET
F.1	Ref	CRSRehab	Registration Form	✓	✓	✓	✓	✓
Annex 1 to CRSRehab-VI Form 1	Ref	CRSRehab	Visual Examination Form for Admission to Care & Attention Home for the Aged Blind	×	×	✓	×	×
F.1A	CRSRehab	Ref	Confirmation of Registration	✓	✓	✓	✓	✓
F.1B	CRSRehab	Ref	申請康復服務登記書	✓	✓	✓	✓	✓
Annex to F.1B	CRSRehab	Ref	Notification of Assessment Result	✓	×	×	×	×
F.1C	CRSRehab	Ref	Registration of Assessment Result	✓	×	×	×	×
F.1D	Ref	CRSRehab	Updating on Family Coping Condition	✓	×	×	×	×
F.1E	Ref	CRSRehab	Medical Enquiry Form for Application of Part VII E3 of CRSRehab-IPD Form 1	✓	×	×	×	×
F.1F	RU	CRSRehab	Application for Transfer to Other Residential Care Unit for Persons with Disabilities Under Same Service Type	✓	✓	✓	✓	×
F.1G	CRSRehab	RU	Outcome of Application for Transfer to Other Residential Care Unit for Persons with Disabilities Under Same Service Type	✓	✓	✓	✓	×
F.2	Ref	RU	Application Form	×	✓	✓	×	✓
F.3	Ref	CRSRehab	Data Updating Form	✓	✓	✓	✓	✓
F.4	CRSRehab	Ref	Removal from Waiting list	✓	✓	✓	✓	✓
F.4A	CRSRehab	Ref	Transfer from Active Waiting list to the Inactive Waiting List	✓	×	×	×	×
Annex to F.4A	CRSRehab	Ref	Acknowledgement on Transfer to the Inactive Waiting List	✓	×	×	×	×
F.5	RU	CRSRehab	Report of Vacancies	✓	✓	✓	✓	✓
F.6	CRSRehab	Ref	Selection for Placement	✓	✓	✓	✓	✓
F.6A	CRSRehab	RU	Notification of Case Selection to Rehabilitation Unit	✓	✓	✓	✓	✓
F.7	Ref	CRSRehab	Reply to CRSRehab on Selection for Placement	✓	✓	✓	✓	✓
Annex to F.7	Ref	CRSRehab	Day/Residential Care Service for Persons with Intellectual or Physical Disabilities - Medical Examination Form	✓	×	×	×	×
F.7A	CRSRehab	Ref	1st Reminder to Referrer	✓	✓	✓	✓	✓
F.7B	CRSRehab	Ref	2nd Reminder to Referrer	×	✓	×	×	×
F.7C	CRSRehab	Ref	Reminder to Referrer (for annual case review)	✓	×	×	×	×
F.8	CRSRehab	RU	Referral for Admission	✓	✓	✓	✓	✓
F.9	RU	CRSRehab	Report of Case Intake/Discharge	✓	✓	✓	✓	✓
F.9A	CRSRehab	RU	1st Reminder to Rehabilitation Unit	✓	✓	✓	✓	✓
F.9B	CRSRehab	RU	2nd Reminder to Rehabilitation Unit	×	✓	×	×	×
F.10	Ref	CRSRehab	Application for Priority Placement	✓	✓	✓	✓	✓
F.10A	CRSRehab	Ref	Outcome of Application for Priority Placement	✓	✓	✓	✓	✓

Ref: Referrer
RU: Rehabilitation Unit

Updated forms in word format for the above subsystems can be downloaded from the SWD website (https://www.swd.gov.hk/en/pubsvc/rehab/cat_crsrehab/centralref/) or the Online Submission platform (https://www.online-submission.swd.gov.hk) for use
For CRSRehab-PS, please refer to the Manual of Procedures of Central Referral System for Rehabilitation Services-Subsystem for Disabled Pre-schoolers [July 2024 (Revised Edition)].

Forms of the Subsystem for Persons with Intellectual/Physical Disabilities (CRSRehab-IPD)

【RESTRICTED】

Central Referral System for Rehabilitation Services – Subsystem for Persons with Intellectual/Physical Disabilities

Application for Day[Note 1]/Residential Care Services[Note 2] and Standardised Assessment Tool for Residential Care Services for Persons with Disabilities

I. Personal Particulars

1. Name	(English) (Chinese)
2. Sex/Date of Birth	☐Male ☐Female / *(dd) (mm) (yyyy)*
3. HKID No.	, or Certificate of Exemption:
4. Correspondence Address & Tel. No.	Address: Tel. No.:
5. Residential District	Hong Kong & Islands: ☐Central & Western ☐Wan Chai ☐Eastern ☐Southern ☐Islands Kowloon: ☐Kwun Tong ☐Wong Tai Sin ☐Kowloon City ☐Mongkok ☐Yau Ma Tei ☐Sham Shui Po ☐Tseung Kwan O ☐Sai Kung New Territories: ☐Sheung Shui & Fanling ☐Ma On Shan ☐Shatin ☐Tai Po ☐Yuen Long ☐Tuen Mun ☐Tin Shui Wai ☐Tsuen Wan ☐Kwai Chung & Tsing Yi
6. Service Receiving (may choose more than one item)	☐Nil ☐Special School ☐Boarding Section of Special School Community support: ☐District Support Centre ☐Respite Services ☐Integrated Home Care Services ☐Others, please specify: Day training: ☐Integrated Vocational Rehabilitation Services Centre ☐Sheltered Workshop ☐Supported Employment Training for Persons with Disabilities ☐Day Activity Centre Residential care service: ☐Private Hostel ☐Self-financed Rehabilitation Hostel ☐Supported Hostel ☐Hostel for Moderately Mentally Handicapped Persons ☐Hostel for Severely Mentally Handicapped Persons ☐Hostel for Severely Physically Handicapped Persons ☐Care and Attention Home for Severely Disabled Persons Medical treatment: ☐Psychiatric In-patient ☐Non-Psychiatric In-patient ☐Day Hospital ☐Out-patient clinic, please specify:

II. Disability

1. Physical Disability	☐No physical disability *(please proceed to Item 2)* ☐Quadriplegia ☐Paraplegia ☐Hemiplegia ☐Cerebral palsy ☐Loss of upper or lower limbs ☐Loss of hand/foot or finger/toe ☐Others, please specify:
2. Intellectual Disability	☐No intellectual disability ☐Profound ☐Severe ☐Moderate ☐Mild Date of psychological assessment: (dd) (mm) (yyyy)
3. Other Disability (may choose more than one item)	☐Speech impairment ☐Deaf / Hearing impairment ☐Visual impairment (☐Blind/☐Partially impaired) ☐Autism ☐Down Syndrome ☐Mental illness, please specify: ☐Other, please specify:
4. Illness/Health Problem	Please specify if any:
5. Mobility	☐Walk unaided ☐Walk with escort ☐Walk with aid ☐Wheelchair bound ☐Bed ridden
6. Ability to Climb Stairs/Slope	☐Capable to climb stairs/slope by self ☐Climb stairs/slope with other's assistance ☐Unable to climb stairs/slope even with other's assistance
7. Public Transport (Excluding Taxi)	☐Manage without escort ☐Manage with escort ☐Cannot manage with escort
8. Assistive Devices Used	☐Hearing aid ☐Wheelchair ☐Walking aids other than wheelchair ☐Prosthesis / artificial limb ☐Others:
9. Treatment Receiving	☐Occupational therapy ☐Physiotherapy ☐Others:

Note 1 Applicants who apply for day service only (Sheltered Workshop [SW], Integrated Vocational Rehabilitation Services Centre [IVRSC] or Day Activity Centre [DAC]) are only required to fill in Sections I, II, VIII and IX and have no need to go through the assessment of residential need in Sections III to VII.

Note 2 Carer's age is not a prerequisite for conducting assessment or waitlisting for residential care service. Assessor should conduct assessment for applicant requesting residential care service, irrespective of the age of the carer.

III. Nursing Care Need

Area of care	Care item	Score
1. Skin Problem Applicant's skin developed:	4 Bed sore which was extended to bone during the past month. 3 Ulcer or bed sore that required sterile dressing during the past month. 2 Repeated lesions that required observation on infection and sterile dressing during the past month. 1 Recurrent skin problem such as seasonal skin rash that required application of ointment as prescribed by medical practitioners during the past year. 0 None of the above.	
2. Feeding Problem During the past month:	4 Applicant is a person with severe/profound intellectual disability, and required tube feeding. 3 Applicant required thick and easy for the diet, and had frequent choking during feeding. 3 Applicant is not a person with severe/profound intellectual disability, and required tube feeding. 2 Applicant required thick and easy for the diet when feeding. 2 Applicant had swallowing problem. 0 None of the above.	
3. Medication During the past month:	2 Applicant was on long term diabetic/cardiac medication and required monitoring of blood sugar level/heart rate before medication. 2 Applicant required daily insulin injection. 0 None of the above.	
4. Continence Control During the past month:	3 Uncontrolled double incontinence.[Note 3] 3 Applicant used indwelling urinary catheter or stoma and is a person with severe/profound intellectual disability. 2 Applicant used indwelling urinary catheter or stoma and is not a person with severe/profound intellectual disability. 1 Wetting/soiling of pants. 0 None of the above.	
5. Epilepsy Condition Any epileptic seizures during the past three months:	4 Epileptic seizures uncontrollable even with hospitalisation and drug treatment (medical certification required). 2 Has been hospitalised for 6 times or above due to epileptic seizures. 2 Had episodes of epileptic fit causing serious physical injury requiring immediate medical attention and hospitalisation. 1 Had episodes of epileptic fit. 0 None of the above.	
6. Oxygen Therapy Requiring oxygen therapy for a total of 3 months during the past year:	4 Applicant is a person with severe/profound intellectual disability, and can perform daily activities after oxygen therapy. 4 Applicant cannot perform daily activities after oxygen therapy.[Note 4] 3 Applicant is not a person with severe/profound intellectual disability, and can perform daily activities after oxygen therapy. 0 None of the above/Just using Positive Airway Pressure (PAP) Machine without oxygen therapy.	
7. Suctioning During the past month:	4 Required regular suction. 0 None of the above.	
8. Bed Ridden During the past month:	4 Bed ridden and totally dependent in care. 0 None of the above.	
9. Special Nursing Care During the past month:	4 Required Tracheostomy care. 3 Required Continuous Ambulatory Peritoneal Dialysis (CAPD). 0 None of the above.	
	The **highest** score of the above care items	

Note 3 "Double incontinence" refers to unable to control bladder and bowel.
Note 4 "Applicant cannot perform daily activities" refers to applicant develop shortness of breath even with a minor movement.

IV. Functional Impairment[Note 5]

Rating Criteria

0 Applicant completes the task independently (with or without aids) and meets the basic hygiene requirements within reasonable time.

1 Applicant completes the task under supervision or with verbal or physical prompting.

2 Applicant requires physical assistance that does not involve plenty of body transfer or lifting of trunk/body parts for completing the task; usually assistance from 1 person is sufficient to complete task.

3 Applicant requires physical assistance that involves plenty of body transfer or lifting of trunk/body parts for completing the task; usually assistance from 2 persons or above are required to complete the task.

Activities of daily living	Score
1. Bathing and Shampooing 1.1 Bathing (either shower or tub bath) ……..……... ( ) 1.2 Shampooing ……..……..…... ( ) (Please mark the higher score between items 1.1 and 1.2 as the score for Item 1)	
2. Dressing and Undressing 2.1 Dressing upper body, including street cloths and underwear, in sitting or standing position (excludes buttoning) .....( ) 2.2 Dressing lower body, including street cloths and underwear, in sitting or standing position (excludes zipping) .....( ) 2.3 Dressing socks & shoes (includes hand splint & prosthesis) .....( ) (Please mark the highest score among items 2.1 to 2.3 as the score for Item 2)	
3. Transfer It refers to task that involves displacement of the entire body from a place to another (e.g., bed ⇆ chair/wheelchair, wheelchair ⇆ toilet seat, etc) Please specify the assistive / mobility aids required:	
4. Toilet Use (either sitting or squatting type toilet), including buttock and perineal cleaning, changing napkins (if applicable), etc. (If the applicant used catheter and stoma at the same time, please put a "×" as the score for Item 4.)	
5. Feeding and Drinking 5.1 Eating (if the applicant relies on tube-feeding, please put a "×" as the score for 5.1) ..... ( ) Type of food: *Normal diet / Chopped diet / Minced Feeding aids: *Angled Spoon / Enlarged-handle Spoon / Non-slip Mat / Special Plate / Others: 5.2 Drinking (if the applicant relies on tube-feeding, please put a "×" as the score for 5.2) ..... ( ) Drinking aids: *Straw / 2-handle Mug / Mug with Cut-out Lip / Mug with Spouted Lip / Others: (Please mark the higher score between items 5.1 and 5.2 as the score for Item 5)	
6. Indoor Mobility (respond either to 6.1or 6.2) 6.1 Indoor walking ..... ( ) Walking aids: *Stick / Tripod / Quadripod / Walking Frame / Walking Frame with Castors / Others: 6.2 Indoor Use of Wheelchair ..... ( ) Type of Wheelchair: *Manual / Power (Please mark the score of the responded item as the score for Item 6)	
Total score of items 1 to 6	

* Delete if inappropriate

If the applicant's performance is constrained by the home environment (e.g. lack of handrails), please specify:

Note 5 Applicant's self-care ability in the past month is evaluated through interview. If deemed necessary, observation on the following activities is recommended: (a) drinking; (b) dressing; (c) transfer e.g., moving to and from bed and chair/wheelchair; and (d) walking indoor.

V. Challenging Behavior

Types of Challenging Behaviors	Items	Score
A. Aggressive Behavior	1. Does the applicant have aggressive behavior(s) towards others (such as punching, slapping, pushing or pulling, kicking, pinching, scratching, pulling hair, biting, using weapons, choking, throttling, etc.) in the past year? 0 No (Please proceed to item B1) 1 Yes	
	2. Are there one or more such episodes causing serious physical injury (requiring immediate medical attention) to others within the last year? 0 No 1 Yes	
B. Self-injurious Behavior	1. Does the applicant have self-injurious behavior(s) (such as skin picking, self-biting, head punching/slapping, head-to-object banging, body-to-object banging, hair removal, body punching/slapping, eye poking, skin pinching, cutting with tools, poking, banging with tools, lip chewing, nail removal, teeth banging, etc.) in the past year? 0 No (Please proceed to item C1) 1 Yes	
	2. Are there such behaviors causing severe self-injury and requiring a medical personnel's immediate attention at least once a month within the past year? 0 No 1 Yes (Please proceed to item C1)	
	3. Are there such self-injurious behaviors occurring at least once a week within the last year? 0 No 1 Yes	
C. Property Destruction Behavior	1. Does the applicant have property destruction behavior(s) (causing damage to furniture, fittings, buildings, vehicles etc by hitting, tearing, cutting, throwing, burning, marking or scratching, etc.) in the past year? 0 No (Please proceed to item D) 1 Yes	
	2. Are there serious property destruction within the past year and/or minor property damage on six or more occasions within the past year? 0 No 1 Yes	
D. Other Challenging Behaviors	Does the applicant have other challenging behaviors such as inappropriate sexual behavior (including exposing self, masturbating in public, groping a member of the public, etc.), offensive behavior (including screaming, regurgitating, noisy behavior, smearing with saliva or faeces, or any similar offensive habits, etc.), repetitive behavior (including rocking of body back and forth, flapping hands, flicking fingers, pacing up and down, constant running, or similar stereotyped behaviors, etc.) in the past year? 0 No 1 Yes (please tick all of the boxes that apply): ☐ inappropriate sexual behavior ☐ offensive behavior ☐ repetitive behavior	
E. Coping Difficulty	(Continue to administer item E only when there is at least a score of 1 on items A1, B1, C1 or D.) Does the carer find it very difficult to manage the above situations? 0 No 1 Yes	
		Total score on items A1, B1, C1 and D
		Total score on items A2, B2, B3 and C2*
		Score on item E*

* Please give score 0 to item(s) that is/are not administered.

VI. Family Coping

A. Care System

1. Particulars of Carer(s)

- "Primary carer" and "secondary carer" refer to family members that offer or would offer care or assistance to the applicant, including parents, relatives and kins.
- If the applicant is receiving institutional care, hospital treatment or boarding school service in special school, "primary carer" or "secondary carer" should be the family members who look after the applicant during his/her home leaves or after he/she is discharged from institution or hospital. Their care hours per week may be quite low or even zero.
- If the applicant has no primary or secondary carer, please enter "No" in the corresponding "Name" field.
- Other carer(s) refers to the neighbours, friends, or employed domestic helpers who provide care to the applicant, but not staff of institutions or hospitals.

Types of Carer	Name	Sex	Age	Relationship	Whether Living together	Occupation	Working Hour	Care Hours per Week*
(a) Primary carer								
(b) Secondary carer								
(c) Other carer(s) (may indicate more than one)								

*Calculated by 168 hours (total no. of hours in a week) minus the no. of hours that the applicant receives residential or day care/training (if applicable) and that the carer does not have to care for the applicant.

2. Risks Encountered by the Care System

Due to the following circumstances, the referrer considers that the existing care system is encountering considerable risk(s): 1 The description is applicable to the existing care system 0 The description is not applicable to the existing care system, or the applicant has no primary carer	
(a) The primary carer is 55 years old or above	
(b) The primary carer is deteriorating in physical health condition (e.g. physical strain) or suffering from chronic illnesses and cannot look after the applicant	
(c) The primary carer is a person with physical/intellectual disability or person in mental recovery	
(d) The primary carer is deteriorating in mental health condition or emotionally disturbed and cannot look after the applicant	
(e) The primary carer has to take care of other person(s) with disability or chronic illness and cannot look after the applicant	
(f) The primary carer has long hour work and cannot make other care arrangement for the applicant	
(g) The applicant loses contact with family or relatives and no one can provide care for the applicant	
(h) The applicant is a Ward of Director of Social Welfare, and no family or relatives would provide care	

B. Interpersonal Relationship

Due to the following circumstances, the referrer considers that the interpersonal relationship of the applicant has serious problem: 1 Occurred 0 Not occurred, or the applicant is not living with family members	
1. The applicant had at least two occasions of serious conflict with family member or inmate in the past three months	
2. The applicant had at least two occasions of serious conflict arising from disturbing the neighbours in the past three months	
3. The applicant was hospitalised for psychiatric treatment due to serious conflict with family member. The latter still refuse to accept him/her returning home.	

C. Other Risk Factors

Due to the following circumstances, the referrer considers that there is considerable risk regarding the applicant's safety and has follow-up action(s) accordingly: 1 Occurred 0 Not occurred	
1. The applicant is/was being physically/psychologically/sexually abused by family member	
2. The applicant is/was being physically/psychologically/sexually abused by other person	
3. The applicant is/was being neglected from care	
4. The applicant has uncontrollable behaviour (e.g. runaway, arson or participate in unlawful activities), please specify:	

VII. Conclusion on Residential Care Need Assessment

A. Nursing Care

1. Assessment result of section III (please tick one only)	No or low nursing care need (please put a "×" in A2 and A3 and proceed to B1)	☐
	Moderate nursing care need	☐
	High nursing care need	☐
	Very high nursing care need	☐
2. Is there any family member, relative or other carer who can offer assistance with regard to the situation indicated in section III, such that residential care will not be necessary?	0 Yes, please specify: 1 No × Not applicable	
3. Is there any community support or community nursing service that can offer assistance with regard to the situation indicated in section III, such that residential care will not be necessary?	0 Yes, please specify: 1 No × Not applicable	

B. Functional Impairment

1. Assessment result of section IV (please tick one only)	No functional impairment (please put a "×" in B2 and B3 and proceed to C1)	☐
	Low functional impairment	☐
	Moderate functional impairment	☐
	High functional impairment	☐
2. Is there any family member, relative or other carer who can offer assistance with regard to the situation indicated in section IV, such that residential care will not be necessary?	0 Yes, please specify: 1 No × Not applicable	
3. Is there any community support or day training service that can offer assistance with regard to the situation indicated in section IV, such that residential care will not be necessary?	0 Yes, please specify: 1 No × Not applicable	

C. Challenging Behaviour

1. Assessment result of section V (please tick one only)	No challenging behaviour (please put a "×" in C2 and C3 and proceed to D1)	☐
	Has challenging behaviour but does not need rehabilitation service with more staff	☐
	Has challenging behaviour and needs rehabilitation service with more staff	☐
2. Is there any family member, relative or other carer who can offer assistance with regard to the situation indicated in section V, such that residential care will not be necessary?	0 Yes, please specify: 1 No × Not applicable	
3. Is there any day training, treatment or counseling service that can offer assistance with regard to the situation indicated in section V, such that residential care will not be necessary?	0 Yes, please specify: 1 No × Not applicable	

D. Family Coping

1. Assessment result of section VI (please tick whichever appropriate)	There is considerable risk in applicant's care system	☐
	There is serious problem in the applicant's interpersonal relationship	☐
	There is considerable risk in applicant's safety	☐
If D1 does not indicate any risk in applicant's care system or safety or serious problem in interpersonal relationship, please put a "×" in D2 and D3 and proceed to E1.		
2. Is there any family member, relative or other carer who can offer assistance with regard to the risk in care system, applicant's interpersonal relationship or risk in safety indicated in section VI, such that residential care will not be necessary?	0 Yes, please specify: 1 No × Not applicable	
3. Is there any community support or family service that can offer assistance with regard to the risk in care system, applicant's interpersonal relationship or risk in applicant's safety indicated in section VI, such that residential care will not be necessary?	0 Yes, please specify: 1 No × Not applicable	

E. Assessment Result

1. After considering the above assessment result of Sections A to D, it indicates: (Please choose one item only):	the existing care system, day training or community support services have already provided the applicant and his/her family with adequate assistance. There is no need to wait for residential care services at present. (The applicant can re-apply and be assessed again in the future whenever necessary.)	☐
	the existing care system, day training or community support services cannot provide adequate assistance to the applicant and his/her family. The applicant needs to wait for residential care service.	☐
2. According to the "Service Need Assessment Flowchart" in "Assessor Manual", the type of service recommended to the applicant is: (please choose one item only):	Community Support Service (referrer would make direct application to the service agency concerned), or Day Training, including Sheltered Workshop (SW), Integrated Vocational Rehabilitation Services Centre (IVRSC), Supported Employment Training for Persons with Disabilities (SET) and Day Activity Centre (DAC)	☐
	Community Residential Care Service (referrer would make direct application to the service agency concerned) or Supported Hostel (SHOS)* * (Assessor has to consider the applicant's community living skills, e.g. using public transport, using telephone, shopping, knowledge on road safety, etc., and assess if he/she meets the eligibility criteria of SHOS)	☐
	Hostel for Moderately Mentally Handicapped Persons (HMMH)	☐
	Hostel for Severely Mentally Handicapped Persons (HSMH)	☐
	Hostel for Severely Physically Handicapped Persons (HSPH)	☐
	Care and Attention Home for Severely Disabled Persons (C&A/SD)	☐
	Beyond C&A/SD (Referrer may consider making direct application to the Hospital Authority for Infirmary Service)	☐

3. In case there is situation that is not covered in the above assessment and warrants the need for residential care service or service different from the type of service recommended above, please specify in detail the situation and service recommended to the applicant:

   a. Situation that is not covered in the above assessment:

   b. Reason(s) warranting the need for residential care service/reason(s) warranting the need for residential care service different from the type of service recommended above:

   c. Service recommendation by the assessor:

   d. Endorsement by ADSWO of SWD/agency head of non-governmental organisation/principal of special school:

Signature: _____ Post: _____

Name: (Eng) _____ Tel. No.: _____

(Chi) _____ Date: _____

F. Assessor Information

Name of Assessor: (Chi) _____ Assessor Code: _____

(Eng) _____ Date: _____

VIII. Placement Arrangement

1. Service recommended for applicant (please tick the appropriate item(s) after completing the assessment. If the service recommended is not listed below, please proceed to Declaration and Section IX direct.)

Day Training (referrer should complete Section I and II before completing this part)	☐ Sheltered Workshop/Integrated Vocational Rehabilitation Services Centre (for Persons with Intellectual Disabilities) [SW/IVRSC (MH)] ☐ Sheltered Workshop/Integrated Vocational Rehabilitation Services Centre (for Persons with Physical Disabilities) [SW/IVRSC(PH)] ☐ Sheltered Workshop/Integrated Vocational Rehabilitation Services Centre (for Persons with Visual Impairment) [SW/IVRSC(VI)] ☐ Day Activity Centre (for Persons with Intellectual Disabilities) [DAC(MH)]
Residential Care Services/ Day and Residential Care Services (referrer should complete Section I to VII and confirm that applicant has residential need before completing this part)	☐ Supported Hostel (for Persons with Intellectual Disabilities) [SHOS(MH)] ☐ Supported Hostel (for Persons with Intellectual Disabilities and Visual Impairment) [SHOS(MH+VI)] ☐ Supported Hostel (for Persons with Physical Disabilities) [SHOS(PH)] ☐ Hostel for Severely Physically Handicapped Persons (HSPH) ☐ Hostel for Moderately Mentally Handicapped Persons (HMMH) ☐ Sheltered Workshop/Integrated Vocational Rehabilitation Services Centre and Hostel for Moderately Mentally Handicapped Persons (SW/IVRSC and HMMH) ☐ Sheltered Workshop/Integrated Vocational Rehabilitation Services Centre and Hostel for Severely Physically Handicapped Persons (SW/IVRSC and HSPH) ☐ Day Activity Centre and Hostel for Severely Mentally Handicapped Persons [DAC & H(MH)] ☐ Care and Attention Home for Severely Disabled Persons (for Persons with Intellectual or Physical Disabilities) (C&A/SD)
BPS Option [Note 6] for Residential Care Services/ Day and Residential Care Services above	☐ Also apply for private home(s) under BPS (for applicant applying SHOS(MH), SHOS(MH+VI), SHOS(PH), HMMH or SW/IVRSC and HMMH only)

2. Does the applicant willing to accept day training first when waiting for residential care service? ☐Yes ☐No

3. Location Preference

Day Placement	Residential Placement
☐ Applicant has no location preference	☐ Applicant has no location preference and would receive residential care services as soon as possible
☐ Applicant would have the following location preference and understand that the waiting time of receiving the related services would be longer:	☐ Applicant would have the following location preference and understand that the waiting time of receiving the related services would be longer:
1. _____	1. _____
2. _____	2. _____
3. _____	3. _____
	4. _____
	5. _____

Declaration

☐ Referrer has declared that there is no conflict of interest in handling this application. Referrer is not a family member or personal friend of the applicant and has no personal or social ties with the applicant, and she/he has notified the applicant/family member(s)/guardian/carer(s) that SWD and the referring agency will not charge for the application and referral for service. The applicant/family member(s)/guardian/carer(s) should report to the Independent Commission Against Corruption (ICAC) immediately in case anyone offers to assist in application for placement in return for remuneration. Attempted bribery by any person is also an offence in law, SWD will refer the case to ICAC for investigation.

IX. Referrer Information

Case Ref. No.: _____ Service Unit: _____

Name of Referrer: (Chi) _____ Tel./Fax No.: _____ / _____

(Eng) _____ Date: _____

[Note 6] BPS refers to "Bought Place Scheme for Private Residential Care Homes for Persons with Disabilities"

【限閱文件】

康復服務中央轉介系統－智障／肢體傷殘人士子系統
日間訓練[註一]／住宿服務[註二]申請及殘疾人士住宿服務評估工具

I. 申請人個人資料

1. 姓名	(英) (中)
2. 性別／出生日期	□男 □女／ 年 月 日
3. 香港身份證號碼	，或豁免登記證明書號碼：
4. 聯絡地址及電話	地址： 電話：
5. 居住地區	香港島及離島：□中西區 □灣仔 □東區 □南區 □離島 九龍：□觀塘 □黃大仙 □九龍城 □旺角 □油麻地 □深水埗 □將軍澳 □西貢 新界：□上水及粉嶺 □馬鞍山 □沙田 □大埔 □元朗 □屯門 □天水圍 □荃灣 □葵涌及青衣
6. 現正接受的服務（可選擇多項）	□無 □特殊學校 □特殊學校寄宿服務 社區支援服務：□地區支援中心 □暫託住宿服務 □綜合家居照顧服務 □其他，請註明： 日間訓練服務：□綜合職業康復服務中心 □庇護工場 □殘疾人士輔助就業培訓 □展能中心 住宿服務：□私營院舍 □自負盈虧殘疾人士院舍 □輔助宿舍 □中度智障人士宿舍 □嚴重智障人士宿舍 □嚴重肢體傷殘人士宿舍 □嚴重殘疾人士護理院 醫療服務：□精神科住院服務 □非精神科住院服務 □日間醫院服務 □門診服務，請註明：

II. 有關殘疾及健康問題的資料

1. 肢體傷殘	□並非肢體傷殘（請轉答第 2 項） □四肢癱瘓 □下肢癱瘓 □左／右半身不遂 □大腦癱瘓 □缺失上或下肢 □缺失手／腳掌或手／腳趾 □其他，請註明：
2. 智障	□並非智障 □極度嚴重 □嚴重 □中度 □輕度 心理評估日期： 年 月 日
3. 其他殘疾（可選擇多項）	□言語障礙 □聽覺受損／弱聽 □視覺受損（□失明／□弱視） □自閉症 □精神病，請註明： □唐氏綜合症 □其他，請註明：
4. 疾病／健康問題	若有，請註明：
5. 活動能力	□自行走動 □需要他人攙扶走動 □以復康用具輔助走動 □需用輪椅 □需臥床
6. 上樓梯或斜坡的能力	□能自行上樓梯或斜坡 □需要其他人協助上樓梯或斜坡 □在其他人士協助下仍不能上樓梯或斜坡
7. 使用公共交通的能力（的士除外）	□可自行乘搭公共交通工具 □需要他人陪同乘搭公共交通工具 □即使有其他人陪同仍難於乘搭公共交通工具
8. 所使用的輔助工具	□助聽器 □輪椅 □輪椅以外的助行器具 □義肢 □其他：
9. 現正接受的治療	□職業治療 □物理治療 □其他：

註一 日間訓練服務（庇護工場[SW]、綜合職業康復服務中心[IVRSC]或展能中心[DAC]）的申請人，只需填寫第 I、II、VIII 及 IX 部分，無須接受第 III 至 VII 部分的住宿需要評估。

註二 照顧者的年齡並非進行評估或輪候住宿服務的先決條件，不論照顧者的年齡為何，評估員必須為提出申請住宿服務的申請人進行評估。

III. 護理需要

護理範圍	護理項目	分數
1. 皮膚問題 皮膚情況：	4 在過往一個月內褥瘡有見骨情況。 3 在過往一個月內皮膚出現潰瘍、褥瘡需接受無菌換症。 2 在過往一個月內皮膚重覆損傷需觀察傷口發炎情況，並接受無菌換症清洗傷口。 1 在過往一年內因反覆出現皮膚問題需搽醫生處方藥膏，如季節性皮膚病。 0 沒有以上任何一種情況。	
2. 餵食情況 在過往一個月內是否：	4 需用導管餵食，申請人為嚴重／極度嚴重智障人士。 3 使用凝固粉或其他餵食技巧進行餵食，仍經常出現哽塞。 3 需用導管餵食，申請人並非嚴重／極度嚴重智障人士。 2 需加凝固粉進行餵食。 2 有吞嚥問題。 0 沒有以上任何一種情況。	
3. 使用藥物情況 在過往一個月內申請人是否：	2 須長期服用糖尿／心臟藥物，並於服藥前監察血糖水平／心律。 2 需每天接受糖尿藥物注射。 0 沒有以上任何一種情況。	
4. 排泄控制 在過去一個月內的排泄能力：	3 大便及小便完全失禁[註三]。 3 使用導尿管或造口排泄，申請人為嚴重／極度嚴重智障人士。 2 使用導尿管或造口排泄，申請人並非嚴重／極度嚴重智障人士。 1 有遺尿／遺便情況。 0 沒有以上任何一種情況。	
5. 腦癇情況 在過去三個月是否有腦癇發作：	4 腦癇情況經住院治療及調較用藥後仍不能控制（需經醫生證明）。 2 有6次或以上因腦癇發作而接受住院治療。 2 曾有腦癇發作引致自己身體嚴重受傷，需要醫護人員即時治理及接受住院治療。 1 曾有腦癇發作。 0 沒有以上任何一種情況。	
6. 氧氣治療 在過往一年內是否有合共三個月需接受氧氣治療：	4 在使用氧氣後仍能處理日常作息，申請人為嚴重／極度嚴重智障人士。 4 申請人在使用氧氣後仍無法處理日常作息[註四]。 3 在使用氧氣後仍能處理日常作息，申請人並非嚴重／極度嚴重智障人士。 0 沒有以上任何一種情況／只需使用睡眠呼吸機（而非氧氣治療）。	
7. 抽吸處理 在過往一個月內是否：	4 需接受恆常抽吸處理。 0 沒有以上情況。	
8. 長期臥床 在過往一個月內是否：	4 需長期臥床並完全倚賴他人照顧。 0 沒有以上情況。	
9. 特別護理照顧 在過往一個月內是否：	4 需接受氣管造口護理。 3 需接受連續性可攜帶腹膜透析治療（俗稱「洗肚」）。 0 沒有以上情況。	
	上述各項目的**最高**分數	

[註三] 完全失禁指大便及小便在不自覺或不受控制的情況下排出。

[註四] 無法處理日常作息指小量活動便引致氣促。

IV. 功能缺損[註五]

評分準則

0 申請人完全獨立完成該項活動，並在可接受的時間內安全地達至基本衞生要求（包括使用輔助器具）

1 申請人需要別人在旁監督或提示才能完成（包括需要口頭或觸體的提示）

2 申請人需要觸體協助，但不需要大量體位搬移的協助、或提舉申請人身軀或肢體；一般情況下，一人便可協助完成該項目

3 照顧者需給予大量體位搬移的協助、或提舉申請人身軀或肢體才能協助完成該項目；一般情況下需二人或以上人手才可協助完成該項目

活動項目	分數
1. 洗澡及洗頭 1.1 洗澡（進行淋浴或坐浴）…… （ ） 1.2 洗頭 …… （ ） （請選取1.1至1.2的最高分數作為右方項目1的整項分數）	
2. 穿脫衣物 2.1 以坐或站的姿勢穿脫上身衣物，包括外衣及內衣（扣鈕除外）.....（ ） 2.2 以坐或站的姿勢穿脫下身衣物，包括外褲及內褲（拉拉鍊除外）.....（ ） 2.3 穿脫鞋襪（包括手托或義肢）.....（ ） （請選取2.1至2.3的最高分數作為右方項目2的整項分數）	
3. 位置轉移 指身體如何由一處移動至另一處的情況（例：床⇆座椅／輪椅，輪椅⇆座廁等） 請列出所需的輔助工具／助行器具：	
4. 如廁（使用坐廁或蹲廁），包括大小便後的清潔、更換成人尿片（如適用）等 （倘若申請人同時使用導尿管及造口排泄，請於分數格內填上「×」）	
5. 進食及進飲 5.1 進食（倘若申請人使用導管餵食，請於分數括號內填上「×」）.....（ ） 食物種類：*一般／切碎／糊狀 進食輔助工具：*曲羹／粗柄羹／防滑墊／斜邊碟／其他： 5.2 進飲（倘若申請人使用導管餵食，請於分數括號內填上「×」）.....（ ） 進飲輔助工具：*飲管／雙耳杯／切口杯／有蓋啜飲杯／其他： （請選取5.1至5.2的較高分數作為右方項目5的整項分數）	
6. 室內行動能力（只需回答6.1或6.2） 6.1 室內行走 .....（ ） 使用的助行器具：*手杖／三或四腳手杖／助行架／輪子助行架／其他： 6.2 室內使用輪椅 .....（ ） 輪椅類別：*手動／電動 （請選取適用的分項作為右方項目6的整項分數）	
項目1至6的**總分**	

* 刪去不適用者

申請人有否因家居環境問題（如缺乏合適的扶手裝置）而減低其上述功能表現？若有，請註明：

[註五] 評估是透過面談了解申請人過往一個月的自我照顧能力；若有需要，可現場觀察以下活動進行：(a)喝水、(b)穿衣褲、(c)身體位置轉移（如來回床至座椅、來回輪椅至座椅等）及(d)室內行走。

V. 行為問題

行為問題類別	行為問題項目	分數
A. 攻擊行為	1. 在過去一年內，申請人有否向他人表現攻擊行為（如用拳猛擊他人、掌摑他人、推撞他人、踢人、夾人、抓人、扯人頭髮、咬人、用武器攻擊人、扼人喉嚨等）？ 0 否（請轉問B1項） 1 有	
	2. 在過去一年內，有否發生申請人攻擊人事故，引致他人身體嚴重受傷，需要即時醫治？ 0 否 1 有	
B. 自我傷害行為	1. 在過去一年內，申請人有否表現自我傷害行為（如摑自己，咬自己，拳擊或掌摑自己頭部、撞頭、把身體撞向其他東西、扯脫自己頭髮、拳擊或掌摑自己身體、插自己眼、夾自己、用工具割自己、插自己、用工具撞自己、咬唇、扯脫自己指甲、把牙齒撞向其他東西等）？ 0 否（請轉問C1項） 1 有	
	2. 在過去一年內，申請人有否表現自我傷害行為，引致自己身體嚴重受傷，每月至少一次需要醫護人員即時治理？ 0 否 1 有（請轉問C1項）	
	3. 在過去一年內，申請人有否每星期至少一次表現自我傷害行為？ 0 否 1 有	
C. 破壞行為	1. 在過去一年內，申請人有否表現破壞行為（如用擊打、撕扯、切割、投擲、燒毀、塗污或抓刮方法導致傢俱、家居裝置、建築物、車輛等損毀等）？ 0 否（請轉問D項） 1 有	
	2. 在過去一年內，申請人有否導致嚴重物資破壞，和/或導致六次或以上輕微物資破壞？ 0 否 1 有	
D. 其他行為問題	在過去一年內，申請人有否表現其他行為問題，如不恰當性行為（包括公眾地方暴露自己、公眾地方自慰、滋擾他人等），厭惡行為（包括尖叫、反芻吞下的食物、發出喧鬧聲、用口水或糞便塗污、或其他同類厭惡行為等），重覆行為（包括搖晃身體、重覆翻動手掌、彈手指、踱來踱去、持續奔跑、或同類重覆行為等）？ 0 否 1 有，請註明（可選多項）：☐不恰當性行為 ☐厭惡行為 ☐重覆行為	
E. 應付困難	（當項目A1, B1, C1或D至少一項有1分，方可繼續發問E項。） 請問照顧者在處理以上行為時，覺得非常困難嗎？ 0 否 1 有	
	A1, B1, C1和D項的總分	
	A2, B2, B3和C2項的總分*	
	E項的得分*	

* 任何沒有發問的項目，請給予0分。

VI. 家人／照顧者的應付能力

A. 照顧系統

1. 照顧者資料

- 「主要照顧者」與「次要照顧者」是指會或將會為申請人提供照顧或協助的家人，包括父母、家屬或親人。
- 如果申請人現正接受院舍、醫院或特殊學校寄宿服務，則以申請人回家渡假時或離開院舍後，會照顧申請人的家人為「主要照顧者」及「次要照顧者」。在這情況之下，他們的「每週照顧時數」可能會較低甚至為零。
- 倘若申請人沒有主要或次要照顧者，請於相關的「姓名」一欄填「無」。
- 「其他照顧者」是指會提供協助的鄰居、朋友，或受聘照顧申請人的家庭傭工，但不包括院舍或醫院職員。

照顧者類別	姓名	性別／年齡	關係	是否同住	職業	工作時間	每週照顧時數*
(a) 主要照顧者							
(b) 次要照顧者							
(c) 其他照顧者（可多於一位）							

*計算方法為將一星期共168小時減去申請人接受住宿照顧或日間照顧／訓練(如適用)及照顧者不用提供照顧的時數。

2. 照顧系統所面臨的危機

由於出現以下情況，評估員認為現有照顧系統已面臨相當的危機或風險： 1 出現所述的情況 0 沒有所述的情況，或申請人沒有主要照顧者	
(a) 主要照顧者年齡已達 55 歲或以上	
(b) 主要照顧者身體健康轉差（例如:身體勞損）或有長期病患，以致無法照顧申請人	
(c) 主要照顧者為肢體傷殘人士、智障人士或精神復元人士	
(d) 主要照顧者出現精神健康轉差或情緒困擾，以致無法照顧申請人	
(e) 主要照顧者需同時照顧其他殘疾或長期病患的家庭成員，以致無法照顧申請人	
(f) 主要照顧者需長時間工作，且無能力安排其他照顧者照顧申請人	
(g) 申請人無法與家人及親友聯絡，亦無人可提供所需照顧	
(h) 申請人為社會福利署署長監護個案，並無家人或親友可提供所需照顧	

B. 人際關係

由於出現以下情況，評估員認為申請人現時的人際關係已出現嚴重問題： 1 出現所述的情況 0 沒有所述的情況，或申請人沒有與家人同住	
1. 申請人在過去三個月內，曾至少兩次與家人或同住者發生嚴重衝突	
2. 申請人在過去三個月內，曾至少兩次滋擾鄰居而引致嚴重衝突	
3. 申請人曾與家人發生嚴重衝突，並需接受精神科住院治療，至今家人仍拒絕接納申請人回家	

C. 其他風險／危機因素

由於以下的情況，評估員認為申請人的安全現時存在相當危機或風險，並曾作出適當跟進： 1 出現所述的情況 0 沒有所述的情況	
1. 申請人被家人虐待或侵犯（包括身體虐待、心理虐待、性侵犯等）	
2. 申請人被其他人士虐待或侵犯（包括身體虐待、心理虐待、性侵犯等）	
3. 申請人被疏忽照顧	
4. 申請人有不受控制行為（包括離家出走、縱火、參與非法活動等），請註明：	

VII. 住宿需要評估總結

A. 護理需要

1.第III部分評估結果（只勾選一項）	沒有／低度護理需要 （請於A2及A3填上「×」並轉答B1）	
	中度護理需要	
	高度護理需要	
	極高護理需要	
2.現時有沒有家人、親友或其他照顧者可就第III部分護理需要評估所顯示的情況提供協助，讓申請人無需接受住宿照顧？	0　有，請註明： 1　沒有 ×　不適用	
3.現有社區支援或社康護理服務能就第III部分護理評估所顯示的情況提供協助，讓申請人無需接受住宿照顧？	0　能夠，請註明： 1　不能夠 ×　不適用	

B. 功能缺損

1.第IV部分評估結果（只勾選一項）	沒有功能缺損（請於B2及B3填上「×」並轉答C1）	
	低度功能缺損	
	中度功能缺損	
	高度功能缺損	
2.現時有沒有家人、親友或其他照顧者可就第IV部分功能缺損評估所顯示的情況提供協助，讓申請人無需接受住宿照顧？	0　有，請註明： 1　沒有 ×　不適用	
3.現有社區支援或日間訓練能否就第IV部分功能缺損評估所顯示的情況提供協助，讓申請人無需接受住宿照顧？	0　能夠，請註明： 1　不能夠 ×　不適用	

C. 行為問題

1.第V部分評估結果（只勾選一項）	沒有行為問題（請於C2及C3填上「×」並轉答D1）	
	有行為問題，但無需有較多員工的康復服務	
	有行為問題，並需要有較多員工的康復服務	
2.現時有沒有家人、親友或其他照顧者可就第V部分所顯示的行為問題提供協助，讓申請人無需接受住宿照顧？	0　有，請註明： 1　沒有 ×　不適用	
3.現有日間訓練、治療或輔導服務能否就第V部分所顯示的行為問題提供協助，讓申請人無需接受住宿照顧？	0　能夠，請註明： 1　不能夠 ×　不適用	

D. 家人／照顧者的應付能力

1.第VI部分評估結果（請勾選適用的項目）	現有照顧系統已面臨相當的危機	
	申請人的人際關係已出現嚴重問題	
	申請人的安全存在相當的危機或風險	
倘若D1部分沒有顯示任何的照顧系統危機、申請人的人際問題或安全風險，請於D2及D3填上「×」並轉答E1		
2.現時有沒有家人、親友或其他照顧者可就第VI部分所顯示的照顧系統危機、申請人的人際問題或安全風險提供協助，讓申請人無需接受住宿照顧？	0　有，請註明： 1　沒有 ×　不適用	
3.現有社區支援、家庭服務等能否就第VI部分所顯示的照顧系統危機、申請人的人際問題或安全風險提供協助，讓申請人無需接受住宿照顧？	0　能夠，請註明： 1　不能夠 ×　不適用	

E. 評估結果

1. 綜合上述A至D項評估結果，顯示（只勾選一項）：	現有照顧系統、日間訓練或社區支援服務等已能提供申請人或家人所需的協助，現階段並不需要輪候院舍服務（倘若申請人日後有需要，可再行申請及進行評估）	
	現有照顧系統連同日間訓練、社區支援服務等均不能提供申請人或家人所需的協助，申請人有需要輪候院舍服務	
2. 根據《評估員手冊》中的《服務需要評估流程》，建議申請人所需服務類別為（只勾選一項）：	社區支援服務（評估員將直接向有關服務機構申請）或日間訓練服務，包括庇護工場(SW)、綜合職業康復服務中心(IVRSC)、殘疾人士輔助就業培訓(SET)及展能中心(DAC)	
	社區住宿服務（評估員將直接向有關服務機構申請）或輔助宿舍(SHOS)* *（評估員須考慮申請人的社區生活能力，如使用交通工具、使用電話、購物、道路安全知識等，是否符合入住輔助宿舍的條件）	
	中度智障人士宿舍(HMMH)	
	嚴重智障人士宿舍(HSMH)	
	嚴重肢體傷殘人士宿舍(HSPH)	
	嚴重殘疾人士護理院(C&A/SD)	
	評估結果超逾嚴重殘疾人士護理院範圍（轉介者可考慮向醫院管理局申請療養院服務）	

3. 倘若出現評估過程未有提及的情況而導致申請人需要輪候院舍服務或需要輪候跟上述建議服務類別不同的院舍服務，請詳細列明及建議所需服務類別，並須獲得有關的區助理福利專員／機構負責人／學校校長簽署認同：

a. 評估過程未有提及的情況

b. 申請人需要輪候院舍服務的原因／申請人需要輪候跟上述建議服務類別不同的院舍服務的原因

c. 評估員建議所需服務的類別

d. 分區助理福利專員／機構負責人／學校校長簽署

簽署：＿＿＿＿＿＿＿＿　職位：＿＿＿＿＿＿＿＿

姓名：(英)＿＿＿＿＿＿＿＿　電話：＿＿＿＿＿＿＿＿

(中)＿＿＿＿＿＿＿＿　日期：＿＿＿＿＿＿＿＿

F. 評估員資料

評估員姓名：(中)＿＿＿＿＿＿＿＿　評估員編號：＿＿＿＿＿＿＿＿

(英)＿＿＿＿＿＿＿＿　日期：＿＿＿＿＿＿＿＿

VIII. 服務安排

1. 申請人所需服務（請於完成評估後，在此勾選適用的項目。如以下的選項並沒有申請人所需的服務，請直接前往聲明及第 IX 部分。）

日間訓練 （須先完成本表格第I及II部分）	☐ 庇護工場／綜合職業康復服務中心（為智障人士而設） ☐ 庇護工場／綜合職業康復服務中心（為肢體傷殘人士而設） ☐ 庇護工場／綜合職業康復服務中心（為弱視人士而設） ☐ 展能中心（為智障人士而設）
住宿／ 日間訓練及住宿服務 （須先完成第I至VII部分的全部評估，並確認有住宿需要方能輪候）	☐ 輔助宿舍（為智障人士而設）　☐ 輔助宿舍（為智障及弱視人士而設） ☐ 輔助宿舍（為肢體傷殘人士而設） ☐ 嚴重肢體傷殘人士宿舍 ☐ 中度智障人士宿舍 ☐ 庇護工場／綜合職業康復服務中心及中度智障人士宿舍 ☐ 庇護工場／綜合職業康復服務中心及嚴重肢體傷殘人士宿舍 ☐ 展能中心及嚴重智障人士宿舍 ☐ 嚴重殘疾人士護理院（為智障或肢體傷殘人士而設）
私營殘疾人士院舍買位計劃[註六]下的住宿／日間訓練及住宿服務	☐ 同時申請買位院舍（只限於**為智障／肢體傷殘／智障及弱視人士而設的輔助宿舍、中度智障人士宿舍、庇護工場／綜合職業康復服務中心及中度智障人士宿舍**的申請人）

2. 申請人是否希望在輪候住宿服務期間，先接受日間訓練服務？ ☐ 是 ☐ 否

3. 地區選擇

日間訓練	住宿服務
☐ 申請人沒有地區選擇 ☐ 申請人希望選擇以下地區或服務單位，並明白輪候服務時間可能會因此增加： 1. _____ 2. _____ 3. _____	☐ 申請人沒有地區選擇，希望儘快入住院舍 ☐ 申請人希望選擇以下地區或服務單位，並明白輪候服務時間可能會因此增加： 1. _____ 2. _____ 3. _____ 4. _____ 5. _____

聲明

☐ 轉介者現申報處理這申請不會構成利益衝突，轉介者並非申請人的家屬或私交好友，與申請人亦無個人或社交聯繫；及轉介者已經通知申請人／家屬／監護人／照顧者就上述服務的申請及轉介事宜，社會福利署(社署)及轉介機構不會收取任何費用。若有人藉詞協助申請而索取利益，申請人／家屬／監護人／照顧者應立即向廉政公署舉報。任何人意圖行賄，亦屬違法，社署會將個案轉介廉政公署查究。

IX. 轉介者資料

個案編號：_____　轉介單位：_____

轉介者姓名：(英)_____　電話／傳真：_____／_____

(中)_____　日期：_____

[註六]「買位院舍」即已參與「私營殘疾人士院舍買位計劃」的院舍

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Confirmation of Registration

From: Central Referral System for Rehabilitation Services
Subsystem for Person with Intellectual/Physical Disabilities
Social Welfare Department
6/F, West Coast International Building
290-296 Un Chau Street, Sham Shui Po, Kowloon

To:

CRSRehab-IPD Tel.: 3586 3809 / 3586 3826 / 3422 3995 Your Ref.:
Fax: 3755 4946 Your Fax:
Date:

The following applicant has been registered in CRSRehab-IPD for rehabilitation service. Please kindly verify the following data, raise amendment and update any subsequent change to CRSRehab-IPD by *Form 3* (Section I, II or VIII only) or *Form 1* (including but not limited to Section III to VII). For case enquiries, please contact the staff-on-duty at 3586 3647 / 3586 3648. For data protection, only enquiries from the referrer will be answered.

I. Personal Particulars

Name (English):
Name (Chinese):
Sex: Date of Birth:
HKIC No.: Residential district:
Service received:

II. Disability

Physical disability: Mobility:
Intellectual disability: Climb stairs/slope:
Date of assessment: Public transport:
Other disability/illness: Rehabaid used:
Treatment receiving:

III. Nursing Care Needs

	Score		Score		Score
Skin Problem:		Feeding Problem		Medication:	
Continence Control:		Epilepsy Condition:		Oxygen Therapy:	
Suctioning:		Bed Ridden:		Special Nursing Care:	
				Overall:	

IV. Functional Impairment

	Score		Score		Score
Bathing and Shampooing:		Dressing and Undressing:		Transfer:	
Toilet Use:		Feeding and Drinking:		Indoor Mobility:	
				Overall:	

V. Challenging Behaviour

		Score(s)			
Aggressive Behaviours:	A1:		A2:		
Self-injurious Behaviours:	B1:		B2:	B3:	
Property Destruction Behaviours:	C1:		C2:		
Other Challenging Behaviours:	D:				
Coping Difficulty	E:				

Total scores on items A1, B1, C1 & D: _____ **Total scores on items A2, B2, B3 and C2:** _____
Score on item E: _____

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VI. Family Coping

A1. Care System

Types of carer	Name	Sex/Age	Relationship	Live Togthr.	Occupation/Wkg. Hr.	Care Hrs/Wk.
(a) Primary carer		/			/	
(b) Secondary carer		/			/	
(c) Other carer(s)		/			/	

A2. Risks Encountered by the Care System:
B. Interpersonal Relationship:
C. Other Risk Factors:

VII. Conclusion on Residential Care Need Assessment

A. Nursing Care
Level of nursing care:
Whether family can offer assistance:
Whether social service can offer assistance:

B. Functional Impairment
Level of functional impairment:
Whether family can offer assistance:
Whether social service can offer assistance:

C. Challenging Behaviour
Whether there is challenging behaviour:
Whether family can offer assistance:
Whether social service can offer assistance:

D. Family Coping
Problem/Risk:
Whether family can offer assistance:
Whether social service can offer assistance:

E. Assessment Result
Whether there is need for residential care service at present:
Service recommended according to the Assessor Manual:
Whether justification for altering the assessment result is provided:
Whether the justification is approved:

VIII. Placement Arrangement

Service:

Application date:
(i) Residential
(ii) Day
CRSRehab no.:

Availability for day service:
Waiting List:
Location preference:

Day placement

Residential placement

( )
Oi/c CRSRehab-IPD

限閱文件
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社會福利署
康復服務中央轉介系統
申請康復服務登記書
Notification of Registration for Rehabilitation Services
Central Referral System for Rehabilitation Services
Social Welfare Department

致： 康復服務申請人（經個案社工／轉介者轉交）
To: Applicant (Via Caseworker/Referrer)

下列申請經已於社會福利署（社署）康復服務中央轉介系統內登記，詳情如下：
The following application has been registered in the Central Referral System for Rehabilitation Services of the Social Welfare Department (SWD) with details listed as below:

姓名：
Name: _____
香港身份證：
Hong Kong Identity Card: _____
申請日期：
Date of Application: _____
申請輪候的康復服務：
Rehabilitation Service(s) Applying for: _____
輪候狀況：
Status on Waiting List: _____
檔案號碼：
Your Reference: _____
申請人編號：
CRSRehab No.: _____
服務地區選擇：
Location Preference: _____

倘若你獲得編配所申請的服務，康復服務中央轉介系統將會透過你的個案社工／轉介者與你聯絡，安排接受有關服務。為令各方面保持緊密聯絡，若果你的聯絡地址、電話或所需的服務已轉變，請儘快通知個案社工／轉介者，以便他／她將有關資料轉達本系統。就上述服務的申請及轉介事宜，社署及轉介機構不會收取任何費用。若有人藉詞協助申請而索取利益，申請人應立即向廉政公署舉報。任何人意圖行賄，亦屬違法，社署會將個案轉介廉政公署查究。

Once you are selected for a placement in rehabilitation unit, the Central Referral System for Rehabilitation Services will inform you via the Caseworker/Referrer to prepare for acceptance of placement offer. For maintaining good contacts among all parties concerned, please inform the Caseworker/Referrer as early as possible if you have changes in your address, telephone number or rehabilitation services required, so that information may be updated at the Central Referral System for Rehabilitation Services. SWD and the referring agency will not charge for the application and referral for service. The applicant should report to the Independent Commission Against Corruption (ICAC) immediately in case anyone offers to assist in application for placement in return for remuneration. Attempted bribery by any person is also an offence in law, SWD will refer the case to ICAC for investigation.

如你對以上的申請有任何查詢，請與你的個案社工／轉介者聯絡：
Should you have any enquiry on the above application, you may contact your Caseworker/Referrer:
個案社工／轉介者姓名：
Caseworker/Referrer Name: _____
機構名稱：
Centre Name: _____
辦公室地址：
Office Address: _____
聯絡電話（內線）：
Phone Contact No. (ext.): _____

After explanation by the Caseworker/Referrer, I ,_____, the applicant/family member(s)/carer(s)/guardian* of _____, understand and agree that the application has been registered in the Central Referral System for Rehabilitation Services of the Social Welfare Department (SWD).

經個案社工／轉介者解釋，本人_____，為*服務申請人／_____的家屬／照顧者／監護人*明白及同意申請經已於社會福利署康復服務中央轉介系統內登記。

服務申請人／家屬／照顧者／監護人*：
Applicant/family member(s)/carer(s)/guardian *: _____

簽署日期：
Date of Signature: _____

*刪去不適用者
*Delete whichever is inapplicable

To : _____

Date: _____

Notification of Assessment Result

You have received the Standardised Assessment for Residential Care Services for Persons with Disabilities on _____ (Date). The assessment result is as follows:

□ You are suitable for _____ service.

□ Your residential care services need is not confirmed. Hence, your application for residential care services is rejected.

□ You are not suitable for residential care services for persons with disabilities. Please apply to the Hospital Authority for Infirmary Service.

Please note that this assessment result is based on your current situation. If you disagree with the assessment result, you may lodge an appeal to the Secretariat to Appeal Panel for Standardised Assessment for Residential Care Services for Persons with Disabilities (Address: 6/F, West Coast International Building, 290-296 Un Chau Street, Sham Shui Po, Kowloon) within 6 weeks from the date of this notification.

If you encounter any changes in health and family conditions in future, you may *re-apply for residential care services/apply for change of service waitlisted. Examples of the changes include:

(i) significant changes in health condition or need for nursing/personal care;

(ii) increase or decrease in challenging or uncontrollable behaviour;

(iii) significant changes in physical and psychological condition of primary carer;

(iv) changes in family circumstances leading to different caring pattern for the applicant; and

(v) any significant event, e.g. abuse or neglect incident concerning the applicant or the family members.

You may approach the social workers of the Rehabilitation Services Units you are currently attending/Medical Social Services Units/Integrated Family Services Centres at your home vicinity for arrangement of re-assessment of your residential care services needs.

If you have any enquiries, please contact our social worker _____ at _____.

_____

(Referring Social Worker)

_____

(Service Unit)

**Please delete as inapplicable*

致　　先生／女士：

評估結果通知書

你於 20____年____月____日所接受的殘疾人士住宿服務評估，結果如下：

☐ 你適宜接受 _____ 服務。

☐ 你的住宿服務需要未被確定，因此你的住宿服務申請並未被接納。

☐ 你不適宜殘疾人士住宿服務，可向醫院管理局申請療養院服務。

這個評估結果是基於申請人的現況而得出的，倘若你不滿意評估結果，可於此通知書發出日期起六星期內透過社工或直接經書面向**殘疾人士住宿服務評估上訴專責小組秘書處**提出上訴，地址為：九龍深水埗元州街290-296號西岸國際大廈6樓。

倘若將來你的身體或家庭狀況出現以下轉變，可 *再申請住宿服務/申請其他住宿服務類別：

一、 身體狀況或所需的照顧出現明顯轉變；
二、 行為問題或不受控制行為明顯增加或減少；
三、 主要照顧者的身體狀況出現明顯轉變；
四、 家庭狀況出現轉變而導致對申請人有不同的照顧安排；或
五、 發生一些重要事件，例如申請人或家人受到虐待等。

你可以向正在為你提供服務的康復服務機構／醫務社會服務部／你家居附近的綜合家庭服務中心社工尋求協助，重新評估你的住宿需要。

如你有任何疑問，請致電_____與本辦事處_____社工聯絡。

*刪去不適用者

_____

（個案社工姓名）

_____

（服務單位名稱）

年　　月　　日

Registration of Assessment Result

From: Central Referral System for Rehabilitation Services
Subsystem for Persons with Intellectual/Physical Disabilities
Social Welfare Department
6/F, West Coast International Building
290-296 Un Chau Street, Sham Shui Po, Kowloon

To: ☐

CRSRehab-IPD Tel.: 3586 3809 / 3586 3826 / 3422 3995 Your Ref.:
Fax: 3755 4946 Your Fax:
Date:

Name:

HKIC No.:

The assessment result on the above-named has been registered. The *CRSRehab-IPD Form 1* is returned to you for retention.

☐ Recommendation for residential care services in Part VII E3 of *CRSRehab- IPD Form 1* is approved.

☐ Recommendation for residential care services in Part VII E3 of *CRSRehab- IPD Form 1* is considered not justified; the applicant has been waitlisted for residential care service in accordance with the assessment result.

☐ The applicant is assessed to have no residential care service need. Please consider application for day training service/community support service.

☐ The residential care service need of the applicant is beyond the care level of Care and Attention Home for Severely Disabled Persons. Please consider application for infirmary service.

If you have any question, please contact the staff-on-duty at 3586 3809 / 3586 3826 / 3422 3995 for discussion on the case.

( )
Oi/c CRSRehab-IPD

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Updating on Family Coping Condition

From: _____
(Name of Referring Office)
_____
(Name of Organisation)
_____
(Address of Referring Office)
Ref.: _____
Tel.: _____
Fax: _____
Date: _____

To: Central Referral System for Rehabilitation Services
Subsystem for Persons with Intellectual/Physical Disabilities
Social Welfare Department
6/F, West Coast International Building
290-296 Un Chau Street
Sham Shui Po, Kowloon
3586 3809 (DAC/HSMH/C&A/SD)
3586 3826 (SW/IVRSC/SHOS/HMMH/HSPH)
Tel.: 3422 3995 (Inactive Waitlisting Mechansim)
Fax: 3755 4946

Name: _____ HKIC No.: _____ CRSRehab No.: _____

Date of removal to inactive waiting list: _____

Upon the below case review, the applicant's caring condition has been changed and he/she is in need of residential care services. Please put him/her* back to the active waiting list for RCHD services.

A. Care System

1. Particulars of Carer(s)
   - "Primary carer" and "secondary carer" refer to family members that offer or would offer care or assistance to the applicant, including parents, relatives and kins.
   - If the applicant is receiving institutional care, hospital treatment or boarding school service in special school, "primary carer" or "secondary carer" should be the family members who look after the applicant during his/her home leaves or after he/she is discharged from institution or hospital. Their care hours per week may be quite low or even zero.
   - If the applicant has no primary or secondary carer, please enter "No" in the corresponding "Name" field.
   - Other carer(s) refers to the neighbours, friends, or employed domestic helpers who provide care to the applicant, but not staff of institutions or hospitals.

Types of Carer	Name	Sex	Age	Relationship	Whether Living together	Occupation	Working Hour	Care Hours per Week*
(a) Primary carer								
(b) Secondary carer								
(c) Other carer(s) (may indicate more than one)								

*Calculated by 168 hours (total no. of hours in a week) minus the no. of hours that the applicant receives residential or day care/training (if applicable) and that the carer does not have to care for the applicant.

2. Risks Encountered by the Care System

Due to the following circumstances, the referrer considers that the existing care system is encountering considerable risk(s): 1 The description is applicable to the existing care system 0 The description is not applicable to the existing care system, or the applicant has no primary carer	
(a) The primary carer is 55 years old or above	
(b) The primary carer is deteriorating in physical health condition (e.g. physical strain) or suffering from chronic illnesses and cannot look after the applicant	
(c) The primary carer is a person with physical/intellectual disability or person in mental recovery	
(d) The primary carer is deteriorating in mental health condition or emotionally disturbed and cannot look after the applicant	
(e) The primary carer has to take care of other person(s) with disability or chronic illness and cannot look after the applicant	
(f) The primary carer has long hour work and cannot make other care arrangement for the applicant	
(g) The applicant loses contact with family or relatives and no one can provide care for the applicant	
(h) The applicant is a Ward of Director of Social Welfare, and no family or relatives would provide care	

B. Interpersonal Relationship

Due to the following circumstances, the referrer considers that the interpersonal relationship of the applicant has serious problem: 1 Occurred 0 Not occurred, or the applicant is not living with family members	
1. The applicant had at least two occasions of serious conflict with family member or inmate in the past three months	
2. The applicant had at least two occasions of serious conflict arising from disturbing the neighbours in the past three months	
3. The applicant was hospitalised for psychiatric treatment due to serious conflict with family member. The latter still refuse to accept him/her returning home.	

C. Other Risk Factors

Due to the following circumstances, the referrer considers that there is considerable risk regarding the applicant's safety and has follow-up action(s) accordingly: 1 Occurred 0 Not occurred	
1. The applicant is/was being physically/psychologically/sexually abused by family member	
2. The applicant is/was being physically/psychologically/sexually abused by other person	
3. The applicant is/was being neglected from care	
4. The applicant has uncontrollable behaviour (e.g. runaway, arson or participate in unlawful activities), please specify:	

D. Assessment Result

After considering the above assessment result of item A to C, it indicates that the existing care system, day training or community support services cannot provide adequate assistance to the applicant and his/her* family. His/her* application for residential care service needs to be reactivated.

Remarks

_____

_____

_____

Signature: _____

Name: _____

Post: _____

** Please delete as appropriate*

【限閱文件】

家人／照顧者的應付能力(更新)

由：		致：	社會福利署
	(轉介單位)		康復及醫務社會服務科
			康復服務中央轉介系統-智障／肢體傷殘人士子系統
	(轉介機構)		九龍深水埗元州街290-296號西岸國際大廈6樓
	(轉介單位地址)		
個案編號：			3586 3809 (DAC/HSMH/C&A/SD)
電話：			3586 3826 (SW/IVRSC/SHOS/HMMH/HSPH)
傳真：		電話：	3422 3995 (Inactive Waitlisting Mechansim)
日期：		傳真：	3755 4946

姓名：＿＿＿＿＿＿＿＿ 香港身份證號碼：＿＿＿＿＿＿＿＿ 申請人編號：：＿＿＿＿＿＿＿＿

轉移至「非活躍」輪候冊日期：＿＿＿＿＿＿＿＿

根據以下個案評估，申請人的照顧狀況有變，需要接受住宿照顧服務，請將申請人重新列入「活躍」輪候冊。

A. 照顧系統

1. 照顧者資料

- 「主要照顧者」與「次要照顧者」是指會或將會為申請人提供照顧或協助的家人，包括父母、家屬或親人。
- 如果申請人現正接受院舍、醫院或特殊學校寄宿服務，則以申請人回家渡假時或離開院舍後，會照顧申請人的家人為「主要照顧者」及「次要照顧者」。在這情況之下，他們的「每週照顧時數」可能會較低甚至為零。
- 倘若申請人沒有主要或次要照顧者，請於相關的「姓名」一欄填「無」。
- 「其他照顧者」是指會提供協助的鄰居、朋友，或受聘照顧申請人的家庭傭工，但不包括院舍或醫院職員。

照顧者類別	姓名	性別／年齡	關係	是否同住	職業	工作時間	每週照顧時數*
(a)主要照顧者							
(b)次要照顧者							
(c)其他照顧者（可多於一位）							

*計算方法為將一星期共168小時減去申請人接受住宿照顧或日間照顧／訓練(如適用)及照顧者不用提供照顧的時數。

2. 照顧系統所面臨的危機

由於出現以下情況，評估員認為現有照顧系統已面臨相當的危機或風險： 1 出現所述的情況 0 沒有所述的情況，或申請人沒有主要照顧者	
(a) 主要照顧者年齡已達 55 歲或以上	
(b) 主要照顧者身體健康轉差（例如:身體勞損）或有長期病患，以致無法照顧申請人	
(c) 主要照顧者為肢體傷殘人士、智障人士或精神復元人士	
(d) 主要照顧者出現精神健康轉差或情緒困擾，以致無法照顧申請人	
(e) 主要照顧者需同時照顧其他殘疾或長期病患的家庭成員，以致無法照顧申請人	
(f) 主要照顧者需長時間工作，且無能力安排其他照顧者照顧申請人	
(g) 申請人無法與家人及親友聯絡，亦無人可提供所需照顧	
(h) 申請人為社會福利署署長監護個案，並無家人或親友可提供所需照顧	

B. 人際關係

由於出現以下情況，評估員認為申請人現時的人際關係已出現嚴重問題： 1 出現所述的情況 0 沒有所述的情況，或申請人沒有與家人同住	
1. 申請人在過去三個月內，曾至少兩次與家人或同住者發生嚴重衝突	
2. 申請人在過去三個月內，曾至少兩次滋擾鄰居而引致嚴重衝突	
3. 申請人曾與家人發生嚴重衝突，並需接受精神科住院治療，至今家人仍拒絕接納申請人回家	

C. 其他風險／危機因素

由於以下的情況，評估員認為申請人的安全現時存在相當危機或風險，並曾作出適當跟進： 1 出現所述的情況 0 沒有所述的情況	
1. 申請人被家人虐待或侵犯（包括身體虐待、心理虐待、性侵犯等）	
2. 申請人被其他人士虐待或侵犯（包括身體虐待、心理虐待、性侵犯等）	
3. 申請人被疏忽照顧	
4. 申請人有不受控制行為（包括離家出走、縱火、參與非法活動等），請註明：	

D. 評估結果

綜合上述A至C項評估結果，顯示現有照顧系統連同日間訓練、社區支援服務等均不能提供申請人或其家人所需的協助，申請人有需要輪候院舍服務。請將申請人重新列入「活躍」輪候冊。

備註: _____

_____

_____

簽署：_____

姓名：_____

職位：_____

** 刪去不適用者*

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Day/Residential Care Service for Persons with Disabilities under Central Referral System for Rehabilitation Services – Subsystem for Persons with Intellectual/Physical Disabilities (CRSRehab-IPD)

Medical Enquiry Form for Application of Part VII E3 of CRSRehab-IPD Form 1

(Template - for reference only)

Personal Data of Applicant

Name: (English) _____ (Chinese) _____

Sex/Age/D.O.B. _____ HKIC No. _____

Service recommended: _____

I. Major Diagnosis

1.Intellectual Disability ☐ Mild ☐ Moderate ☐ Severe ☐ Profound ☐ NA

2.Date of psychological assessment: _____

3.Physically Disability Please specify: _____

4.Psychiatric Illness Please specify: _____

5.Medical follow-up interval Once in *weeks / months

II. Need for Special Diet

1. Need for Special Diet ☐ No ☐ Yes, please specify: _____

2. Tube feeding ☐ No ☐ Yes, please specify: ☐ Nasogastric tubes

☐ Percutaneous endoscopic gastrostomy feeding tubes

Present condition:

☐ Stable / ☐ Unstable

☐ Medical follow-up intervals

Once in _____weeks / months

☐ No medical follow-up

III. Doctor's Recommendations:

1. The applicant is physically and intellectually ☐ fit / ☐ unfit for group living.
2. The applicant is / is not * suitable to receive the recommended service mentioned above.
3. Further comments (if any):

Official chop

Doctor's Signature: _____

Name in Block Letter: _____

Hospital/Clinic: _____

Ref. No.: _____

Tel. No.: _____

Date: _____

Remark: This medical enquiry form is valid for 6 months from the date of issue.

☐ *Please tick in the appropriate box*

** Delete where inappropriate*

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Central Referral System for Rehabilitation Services – Subsystem for Persons with Intellectual/Physical Disabilities
康復服務中央轉介系統－智障／肢體傷殘人士子系統
Application for Transfer to Other Residential Care Unit for Persons with Disabilities[1] Under Same Service Type
院友調往其他同類別服務院舍申請書[2]

Part I **第一部分**	**Information of Residential Care Unit** **院舍資料**
Name of Service Unit 院舍名稱	
Service Type 服務類別	☐ Supported Hostel (for Persons with Intellectual Disabilities) [SHOS(MH)] 輔助宿舍（為智障人士而設） ☐ Supported Hostel (for Persons with Intellectual Disabilities and Visual Impairment) [SHOS(MH+VI)] 輔助宿舍（為智障及弱視人士而設） ☐ Supported Hostel (for Persons with Physical Disabilities) [SHOS(PH)] 輔助宿舍（為肢體傷殘人士而設） ☐ Hostel for Severely Physically Handicapped Persons (HSPH) 嚴重肢體傷殘人士宿舍 ☐ Hostel for Moderately Mentally Handicapped Persons (HMMH) 中度智障人士宿舍 ☐ Sheltered Workshop/Integrated Vocational Rehabilitation Services Centre and Hostel for Moderately Mentally Handicapped Persons (SW/IVRSC and HMMH) 庇護工場／綜合職業康復服務中心及中度智障人士宿舍 ☐ Sheltered Workshop/Integrated Vocational Rehabilitation Services Centre and Hostel for Severely Physically Handicapped Persons (SW/IVRSC and HSPH) 庇護工場／綜合職業康復服務中心及嚴重肢體傷殘人士宿舍 ☐ Day Activity Centre and Hostel for Severely Mentally Handicapped Persons [DAC & H (MH)] 展能中心及嚴重智障人士宿舍 ☐ Care and Attention Home for Severely Disabled Persons (for Persons with Intellectual or Physical Disabilities) (C&A/SD) 嚴重殘疾人士護理院（為智障或肢體傷殘人士而設）

Part II **第二部分**	**Particulars of Resident** **院友資料**				
Name 姓名		Sex 性別		Age/ D.O.B. 年齡／出生日期	
HKIC No. 香港身份證號碼				Date of Admission 入住宿舍日期	
Intellectual Disability 智障	☐No intellectual Disability 並非智障	☐Profound 極度嚴重	☐Severe 嚴重	☐Moderate 中度	☐Mild 輕度
	Date of psychological assessment 心理評估日期				

Part III **第三部分**	**Reason (s) of Application for Transfer** **申請調院原因**

[1] This Application Form must be completed by social worker / nurse of existing residential care unit
[2] 本申請書必須由申請人現時居住的院舍社工／護士填寫

Part IV **第四部分**	**Functional Condition and Implication for Care (During the past month)** **身體機能狀況及日常照顧注意事項 (申請人過去一個月的狀況)**							
Skin Condition 皮膚情況	☐	Had ulcer or bed sore 皮膚出現潰瘍或褥瘡	☐	Repeated lesions or infection and sterile dressing required 皮膚重覆損傷發炎，並接受無菌換症清洗傷口	☐	Required application of ointment as prescribed by medical practitioners 需搽醫生處方藥膏	☐	None of the above 沒有以上任何一種情況
Feeding 餵食情況	☐	Required tube feeding 需用導管餵食	☐	Required thick and easy for the diet 需加凝固粉進行餵食	☐	Had swallowing problem 有吞嚥問題	☐	None of the above 沒有以上任何一種情況
Medication 使用藥物情況	☐	On long term diabetic / cardiac medication 須長期服用糖尿／心臟藥物	☐	Required monitoring of blood sugar level / heart rate 需監察血糖水平／心律	☐	Required daily insulin injection 需每天接受糖尿／藥物注射	☐	None of the above 沒有以上任何一種情況
Continence Control 排泄控制	☐	Uncontrolled double incontinence 大小便完全失禁	☐	Used indwelling urinary catheter or stoma 使用導尿管或造口排泄	☐	Wetting/ soiling of pants 有遺尿／遺便情況	☐	None of the above 沒有以上任何一種情況
Epilepsy Condition (during the past 3 months) 腦癇情況 (在過去三個月)	☐	Uncontrollable epileptic seizures 腦癇情況不能控制	☐	Frequent epileptic seizures 經常腦癇發作	☐	Had episodes of epileptic fit 曾有腦癇發作	☐	None of the above 沒有以上任何一種情況
Mobility 活動能力	☐	Wheelchair bound 需用輪椅	☐	Walk with aid 以復康用具輔助走動	☐	Walk with escort 需要他人攙扶走動	☐	Walk unaided 自行走動
A.D.L. 自我照顧能力	☐	Independent 完全獨立／不需協助 (No supervision or assistance needed in all daily living activities, including bathing, dressing, toileting, transfer, urinary and faecal continence and feeding) （於洗澡、穿衣、如廁、位置轉移、大小便控制及進食方面均無需指導或協助）						
	☐	Occasional assistance需要監督或提示 (Need supervision or assistance or verbal/physical prompting in bathing and other daily living activities) （於洗澡時及其他日常生活活動方面需要指導或協助）						
	☐	Frequent assistance 經常需要協助 (Need supervision or physical assistance in bathing and other daily living activities which does not involve plenty of body transfer or lifting of trunk/body parts for completing the task; usually assistance from 1 person is sufficient to complete task) （於洗澡及其他日常生活活動方面需要觸體協助，但不需要大量體位搬移的協助、或提舉申請人身軀或肢體；一般情況下，一人便可協助完成該項目）						
	☐	Totally dependent 完全需要協助 (Need physical assistance in all daily living activities that involves plenty of body transfer or lifting of trunk/body parts for completing the task; usually assistance from 2 persons or above are required to complete the task) （於日常生活活動方面均需要完全的協助或需給予大量體位搬移的協助、或提舉申請人身軀或肢體才能協助完成該項目；一般情況下需二人或以上人手才可協助完成該項目）						
Other Nursing/ Care Needs 其他護理／照顧需要	☐	Required Tracheostomy care 需接受氣管造口護理	☐	Required oxygen therapy 需接受氧氣治療	☐	Required regular suction 需接受恆常抽吸處理	☐	Nil 沒有其他護理／照顧需要
	☐	Required Continuous Ambulatory Peritoneal Dialysis (CAPD) 需接受連續性可攜帶腹膜透析治療（俗稱「洗肚」）						
Challenging Behavior 行為問題	☐	Aggressive behavior 攻擊行為	☐	Self-injurious behavior 自我傷害行為	☐	Destruction behavior 破壞行為	☐	Inappropriate sexual behavior 不恰當性行為
	☐	Offensive behavior 厭惡行為	☐	Repetitive behavior 重覆行為	☐	None of the above 沒有以上任何一種情況		

Part V **第五部分**	**Location/Service Unit Preference**[3] **地區或服務單位選擇**[4]							
Preferred Region/ District 地區選擇	☐ **Hong Kong & Islands 香港島及離島**							
	☐	Central & Western 中西區			☐	Wan Chai 灣仔	☐	Eastern 東區
	☐	Southern 南區	☐	Islands 離島				
	☐ **Kowloon 九龍**							
	☐	Kwun Tong 觀塘	☐	Wong Tai Sin 黃大仙	☐	Kowloon City 九龍城	☐	Mongkok 旺角
	☐	Yau Ma Tei 油麻地	☐	Sham Shui Po 深水埗	☐	Tseung Kwan O 將軍澳	☐	Sai Kung 西貢
	☐ **New Territories 新界**							
	☐	Sheung Shui & Fanling 上水及粉嶺			☐	Ma On Shan 馬鞍山	☐	Shatin 沙田
	☐	Tai Po 大埔	☐	Tin Shui Wai 天水圍	☐	Tuen Mun 屯門	☐	Yuen Long 元朗
	☐	Tsuen Wan 荃灣	☐	Kwai Chung & Tsing Yi 葵涌及青衣				
Preferred Service Unit 服務單位選擇								

Part VI **第六部分**	**Endorsement by agency head/service coordinator of non-governmental organisation** **機構總幹事／服務總監批核**
Remarks 備註	

Signature: _____ Post: _____

Name: (Eng) _____ Tel. No.: _____

(Chi) _____ Date: _____

Part VII **第七部分**	**Information of the Referrer and Declaration** **轉介者資料及聲明**

Referrer has declared that there is no conflict of interest in handling this application. Referrer is not a family member or personal friend of the applicant and has no personal or social ties with the applicant, and she/he has notified the applicant/family member(s)/guardian/carer(s) that SWD and the referring agency will not charge for the application and referral for service. The applicant/family member(s)/guardian/carer(s) should report to the Independent Commission Against Corruption (ICAC) immediately in case anyone offers to assist in application for placement in return for remuneration. Attempted bribery by any person is also an offence in law and SWD will refer the case to ICAC for investigation.

轉介者現申報處理這申請不會構成利益衝突，轉介者並非申請人的家屬或私交好友，與申請人亦無個人或社交聯繫；及轉介者已經通知申請人／家屬／監護人／照顧者就上述服務的申請及轉介事宜，社會福利署（社署）及轉介機構不會收取任何費用。若有人藉詞協助申請而索取利益，申請人／家屬／監護人／照顧者應立即向廉政公署舉報。任何人意圖行賄，亦屬違法，社署會將個案轉介廉政公署查究。

Signature: _____ Case Ref. No.: _____

Name: (Eng) _____ Tel. No.: _____

(Chi) _____ Fax No.: _____

Post: _____ Date: _____

[3] Applicant could choose either a specific region/ district or a specific service unit. It is the responsibility of the referrer to make sure that the chosen district has the type of services that suits the applicant.

[4] 申請人只可於地區或服務單位中選擇其中一項。轉介者須確定申請人所選地區／服務單位有提供申請人所需的服務類別。

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Outcome of Application for Transfer to Other Residential Care Unit for Persons with Disabilities Under Same Service Type

From: Central Referral System for Rehabilitation Services
Subsystem for Persons with Intellectual/Physical Disabilities
Social Welfare Department
6/F, West Coast International Building
290-296 Un Chau Street, Sham Shui Po, Kowloon

To:

CRSRehab-IPD Tel.:	3586 3809 / 3586 3826	Your Ref.:	
Fax:	3755 4946	Your Tel:	
Date:		Your Fax:	

Name:

HKIC No.:

CRSRehab No.:

The application for transfer to other residential care unit under same service type of the above-named has been received.

☐ Applicant has been **put back to the active waiting list**. The application date of residential care service on _____ is retained.

☐ The application is considered not justified and hence not approved. Should there is any change in circumstances in future warranting application for transfer, applicant may make a fresh application again.

( )
Oi/c CRSRehab-IPD

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Data Updating Form

From: _____
(Name of Referring Office)
_____
(Name of Organisation)
_____
(Address of Referring Office)
Ref.: _____
Tel.: _____
Fax: _____
Date: _____

To: Central Referral System for Rehabilitation Services
Subsystem for Persons with Intellectual/Physical Disabilities
Social Welfare Department
6/F, West Coast International Building
290-296 Un Chau Street
Sham Shui Po, Kowloon
3586 3809 (DAC/HSMH/C&A/SD)
3586 3826 (SW/IVRSC/SHOS/HMMH/HSPH)
Tel.: 3422 3995 (Inactive Waitlisting Mechansim)
Fax: 3755 4946

Name: _____ ID No.: _____ CRSRehab No.: _____

Information to be updated: (please ✓ in the appropriate box)

☐ Placement is no longer required. Case can be deleted from CRSRehab-IPD. Please give reason:

- ☐ Applicant has passed away
- ☐ Other reasons (please specify): _____

☐ Applicant is not yet ready for admission to RCHD at the current stage. **I confirm that the applicant is not an existing service user of subvented residential care unit.** Case can be transferred to the inactive waiting list and be reviewed annually.

Note: The applicant/family member(s)/carer(s)/guardian should note that the case would not be selected for RCHD placement as far as the applicant is in the inactive waiting list.

☐ Applicant who is currently on the inactive waiting list is still not yet ready for admission to RCHD. Case can be remained in the inactive waiting list.

☐ Applicant who is currently on the inactive waiting list is now ready for admission to RCHD. Case can be put back to the active waiting list.

- ☐ Change in the applicant's health condition (please also submit CRSRehab-IPD- Form 1)
- ☐ No change in the applicant's health condition (please also submit CRSRehab-IPD Form 1D)

☐ Referring office is changed to: _____

☐ Change in placement request (with original application date be retained) :

- ☐ Applicant is assessed to have other residential care services need under the Standardised Assessment Mechanism. (please also submit CRSRehab-IPD Form 1)
- ☐ For SW/IVRSC and HMMH applicant, change in request for single HMMH [*also apply for private home(s) under BPS#] (please make sure that applicant has secured/engaged in day programme)
- ☐ For single HMMH applicant, change in request for SW/IVRSC and HMMH [*also apply for private home(s) under BPS#]
- ☐ For SW/IVRSC and SHOS applicant, change in request for single SHOS [*also apply for private home(s) under BPS#](please make sure that applicant has secured/engaged in day programme)
- ☐ For single SHOS applicant, change in request for SW/IVRSC and SHOS [*also apply for private home(s) under BPS#]

☐ Change in applicant's personal particulars (residential district, disability, etc.):_____

CRSRehab No.:_____

☐ Change in location preference:

☐ Day placement	Residential placement
1. _____	1. _____
2. _____	2. _____
3. _____	3. _____
	4. _____
	5. _____

(for applicant waitlisting for single day rehabilitation service only)

☐ Applicant is discharged/ready for discharge* from hospital. Please put the case back on the active waiting list. Attached please find the updated CRSRehab-IPD Form 1.

☐ Applicant is ready for leaving the school. Please put the case back on the active waiting list. Attached please find the updated CRSRehab-IPD Form 1.

(for day and residential care service applicant only)

☐ Applicant prefers day placement be offered first.

Note : For applicant opted for Inactive Waiting List, the residential care service application would remain inactive.

☐ Applicant prefers day placement be offered with residential placement together.

Remarks

_____

_____

_____

Signature: _____

Name: _____

Post: _____

* *Please delete as appropriate*

BPS refers to "Bought Place Scheme for Private Residential Care Homes for Persons with Disabilities"

c.c. New Referring Office (for reporting change of referring office):

RESTRICTED

Removal from Waiting List

From: Central Referral System for Rehabilitation Services
Subsystem for Persons with Intellectual/Physical Disabilities
Social Welfare Department
6/F, West Coast International Building
290-296 Un Chau Street, Sham Shui Po, Kowloon

To:

CRSRehab-IPD Tel.:	3586 3809 / 3586 3826 / 3422 3995	Your Ref.:	
Fax:	3755 4946	Your Tel:	
Date:		Your Fax:	

Name:

HKIC No.:

CRSRehab No.:

The above-named application has been removed from the waiting list due to the following reason:

☐ Case closed in CRSRehab-IPD upon:

☐ Hospitalisation of applicant. Please refer to the Manual of Procedures for CRSRehab for further information.

☐ Applicant being rejected twice by different agencies in the same service. Please arrange re-assessment of the applicant's genuine service need.

( )
Oi/c CRSRehab-IPD

RESTRICTED

Transfer from Active Waiting List to the Inactive Waiting List

From: Central Referral System for Rehabilitation Services
Subsystem for Persons with Intellectual/Physical Disabilities
Social Welfare Department
6/F, West Coast International Building
290-296 Un Chau Street, Sham Shui Po, Kowloon

To:

CRSRehab-IPD Tel.: 3422 3995 Your Ref.:
Fax: 3755 4946 Your Fax:
Date:

Name:

HKIC No.:

CRSRehab No.:

The residential care service need of the above-named has been confirmed by the Standardised Assessment but he/she is currently not ready for admission to RCHD. His/her application has been **transferred** to the inactive waiting list.

The application date of residential care service on _____ is retained and can be reactivated upon submission of CRSRehab-IPD Form 3 and CRSRehab-IPD Form 1/Form1D.

( )
Oi/c CRSRehab-IPD

康復服務中央轉介系統
智障／肢體傷殘人士子系統
九龍深水埗元州街290-296號
西岸國際大廈6樓

致:申請轉入「非活躍」輪候冊的申請人(經轉介社工轉交):

確認轉入「非活躍」輪候冊

申請人姓名 _____ 康復服務中央轉介系統編號 _____

你申請轉入「非活躍」輪候冊，康復服務中央轉介系統已收悉及確認。

如日後你需要更新任何資料，請聯絡你的轉介社工，以便轉介社工向康復服務中央轉介系統提出。此外，轉介社工將會與你保持聯繫，定期審視你的服務需要。

康復服務中央轉介系統
智障／肢體傷殘人士子系統主管

日期：_____

社會福利署
Social Welfare Department

Central Referral System for Rehabilitation Services
Subsystem for Persons with the Intellectual/Physical Disabilities
6/F., West Coast International Building,
290-296 Un Chau Street,
Sham Shui Po, Kowloon.

Date : _____

To: Applicant applying for transfer to the "Inactive Waiting List"
(Via : Referring Social Worker)

Acknowledgement on Transfer to the Inactive Waiting List

Name of Applicant : _____ CRSRehab No. : _____

Your application for transferring to the "Inactive Waiting List" had been received and processed.

If you need to update any information regarding your application, please contact your referring social worker who would make relevant report to the Central Referral System for Rehabilitation Services accordingly. The responsible social worker will also keep in contact with you and conduct regular review on your service needs.

Officer in Charge
Central Referral System for Rehabilitation Services
Subsystem for Persons with Intellectual/Physical Disabilities

Report of Vacancies

From: _____
(Name of Rehabilitation Unit)
_____
(Name of Organisation)
_____
(Address of Rehabilitation Unit)
Ref.: _____
Tel.: _____
Fax: _____
Date: _____

To: Central Referral System for Rehabilitation Services
Subsystem for Persons with Intellectual/Physical Disabilities
Social Welfare Department
6/F., West Coast International Building
290-296 Un Chau Street
Sham Shui Po, Kowloon

3586 3809 (DAC/HSMH/C&A/SD)
3586 3826 (SW/IVRSC/SHOS/HMMH/HSPH)
Tel.: 3422 3995 (Inactive Waitlisting Mechansim)
Fax: 3755 4946

1. Number of vacancies as at _____ *(date)*:

Service	Day only	Residential only		Day cum residential	
Sex	Both sexes	M	F	M	F
(a) Capacity					
(b) Enrolment					
(c) No. of referral(s) approved and pending admission					
(d) No. of referral(s) being processed					
(e) No. of referral(s) CRSRehab-IPD can send (a – b – c – d)					
Remarks					

2. Number of vacancies anticipated (excluding those reported in item 1):

Service	Day only	Residential only		Day cum residential	
Sex	Both sexes	M	F	M	F
Vacancies					
Available date(s)					
Remarks					

Signature: _____

Name: _____

Post: _____

SWD 644A

RESTRICTED

Selection for Placement

From: Central Referral System for Rehabilitation Services
Subsystem for Persons with Intellectual/Physical Disabilities
Social Welfare Department
6/F, West Coast International Building
290-296 Un Chau Street, Sham Shui Po, Kowloon

To:

CRSRehab-IPD Tel.:	3586 3809 / 3586 3826	Your Ref.:
Fax:	3755 4946	Your Tel:
Date:		Your Fax:

The following applicant has been selected for placement in rehabilitation unit with details shown below. Please reply to CRSRehab by *Form 7* **within 3 week(s)**.

Your early reply will facilitate the applicant's admission for service. You may consider contacting the rehabilitation unit for arrangement of visits for the applicant or information on the service as appropriate. (For priority placement, please review and confirm the applicant still has urgent service need.)

Name of applicant:

HKIC No.:

CRSRehab No.:

Name of Rehabilitation Unit:

Type of Service:

Address:

Tel. No.:

Fax No.:

Date of Selection:

For applicant accepting the placement offer, please forward the following required papers:

1. Form 1
2. Psychological Report
3. Form 7
4. Medical report
5. Case Summary
6. Medical Examination Form (Annex to CRSRehab-IPD Form 7) (Please submit the MEF Directly to the rehabilitation unit concerned)

Please be reminded that you should have declared that there is no conflict of interest in handling the above application. You are not a family member or personal friend of the applicant and has no personal or social ties with the applicant. You should ensure the data collection and transfer of data are authorised by the applicant during the application process.

( )
Oi/c CRSRehab-IPD

RESTRICTED

Notification of Case Selection to Rehabilitation Unit

From: Central Referral System for Rehabilitation Services
Subsystem for Persons with Intellectual/Physical Disabilities
Social Welfare Department
6/F, West Coast International Building
290-296 Un Chau Street, Sham Shui Po, Kowloon

To:

CRSRehab-IPD Tel.: 3586 3809 / 3586 3826 Your Ref.:
Fax: 3755 4946 Your Fax:
Date:

Listed below for your information are the application(s) that have been selected from the waiting list for placement in your service unit. These applicants have 3 week(s)' time to decide whether they accept the placement offer or not. Subject to their acceptance of placement offer, the referrer and/or CRSRehab will send relevant documents to you for case intake once they are available.

While the applicants are considering acceptance of placement offer, they and/or their family members may, through the referring officers, approach your unit for visits or information on services provided.

Since some of the applicants may eventually decline the placement offer, if you need updated referral situation of the above list, please contact the undersigned officer of the CRSRehab.

Name	Gender/ Age	CRSRehab No.	Referring Office	Name of Referrer	Tel	Normal/ Priority

Please be reminded that your staff should have declared that there is no conflict of interest in handling the application(s). They are not a family member or personal friend of the applicant and have no personal or social ties with the applicant.

( )
Oi/c CRSRehab-IPD

RESTRICTED

Reply to CRSRehab-IPD on Selection for Placement

From: _____

_____
(Name of Referring Office and Organization)

_____
(Address of Referring Office)

Tel.: _____ **Fax:** _____

Date: _____ **Ref.:** _____

To: Central Referral System for Rehabilitation Services
Subsystem for Persons with Intellectual/Physical Disabilities
Social Welfare Department
6/F, West Coast International Building
290-296 Un Chau Street
Sham Shui Po, Kowloon

3586 3809 (DAC/HSMH/C&A/SD)
3586 3826 (SW/IVRSC/SHOS/HMMH/HSPH)
Tel.: 3422 3995 (Inactive Waitlisting Mechansim) Fax: 3755 4946

Selection for Placement to ***(name of rehabilitation unit)*****:** _____

Name: _____ **ID No.:** _____ **CRSRehab No.:** _____

☐ **Applicant accepts the offer of day service / applicant is assessed to have need for residential care service under the Standardised Assessment Mechanism *. (For priority placement, the applicant is confirmed to have urgent service need.)**

The following documents are attached:

- ☐ **CRSRehab-IPD Form 1**
- ☐ **Psychological/psychiatric/medical* report**
- ☐ **School progress/VTC* report/Occupational Therapist report**
- ☐ **Case summary**
- ☐ **Medical Examination Form (MEF)**
- ☐ **Certificate of blindness**

☐ **Applicant is assessed to have residential care service need under the Standardised Assessment Mechanism but he/she is not yet ready for admission to RCHD at the current stage. I confirm that the applicant is not an existing service user of subvented residential care unit. Case can be transferred to the inactive waiting list and be reviewed annually.**

Note: The applicant /family members/carer/guardian should note that the case would not be offered RCHD placement as far as the applicant is in the inactive waiting list.

☐ **Applicant is assessed to have other residential care service need under the Standardised Assessment Mechanism.**

☐ **Applicant declines the offer (Please ✓ only one box):**

- ☐ **Applicant considers the location of rehabilitation unit unfavourable.**
- ☐ **Prefer to live with/be looked after by family member(s).**
- ☐ **Satisfied with the present arrangement of day training or community support service.**
- ☐ **Transport not available/cannot be arranged.**
- ☐ **Applicant left Hong Kong or emigrated overseas.**
- ☐ **Lost contact with applicant.**
- ☐ **Applicant passed away.**
- ☐ **Applicant is engaged in open employment at present.**
- ☐ **Applicant is engaged in Supported Employment Training for Persons with Disabilities at present.**
- ☐ **Applicant is attending special school at present.**
- ☐ **Applicant is residing in self-financing or private home.**
- ☐ **Applicant applies for Continuation of Study (COS). The applicant will continue to study in school until _____ (Date)**
- ☐ **Others, please specify:** _____

CRSRehab No.:_____

☐ **Applicant is temporarily hospitalised.**
Name of Hospital:
Admission date:

Please transfer the applicant to the inactive waiting list if he/she is waitlisting for residential care service or paired up day and residential care service.

☐ **Applicant is assessed to have no residential care service need under the Standardised Assessment Mechanism. Case can be deleted from CRSRehab-IPD.**

(for day and residential care service applicant only)

☐ **Applicant prefers day placement be offered first**

Note: For applicant opted for Inactive Waiting List, the residential care service application would remained inactive.

☐ **Applicant prefersday placement be offered with residential placement together.**

Signature: _____

Name: _____

***** ***Please delete as inapplicable***

Post: _____

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Day/Residential Care Service for Persons with Intellectual or Physical Disabilities
Medical Examination Form

Personal Data of Applicant

Name: (English) _____ (Chinese) _____

Sex/Age/D.O.B.: _____ HKIC No.: _____ Tel.: _____

Major Diagnosis

Intellectual Disability ☐ Mild ☐ Moderate ☐ Severe ☐ Profound

Physical Disability Please specify: _____

Psychiatric Illness Diagnosis: _____

Follow-up Interval: _____

Medical History

	No	Yes	If yes, please elaborate:
Symptoms of Infectious Diseases e.g. diarrhea, rash, frequent cough, past chest infection, etc.	☐	☐	_____
Allergy to Food or Drug	☐	☐	_____
Epilepsy	☐	☐	mild (once a month) _____
		☐	moderate (once a week) _____
		☐	severe (once a day) _____
Swallowing Difficulties/Easy Choking	☐	☐	_____
Recent Auditory/Visual Deterioration	☐	☐	_____
Other Significant Illness	☐	☐	_____

Previous Operations	Dates
_____	_____
_____	_____

Current Treatment (specify dosage):	Name(s) of Treatment Providers (e.g. clinic):
_____	_____
_____	_____
_____	_____
_____	_____

Others (please specify): _____

Physical Examination

	Satisfactory	Fair	Poor
General Condition	☐	☐	☐

	Normal	Abnormal	If abnormal, please elaborate:
Skin Condition, e.g. scabies, jaundice	☐	☐	_____
Lymphatic System	☐	☐	_____
Dental Condition	☐	☐	_____
Thyroid	☐	☐	_____
Chest	☐	☐	_____
Cardiovascular System	☐	☐	_____
Abdomen	☐	☐	_____
Limbs, Spine	☐	☐	_____
Possible Signs of Infectious Diseases	☐	☐	_____
	No	Yes	If yes, please specify:
Need for Special Diet	☐	☐	_____

Body Weight: _____ kg Blood Pressure: _____ mmHg Pulse: _____ /min

Other Findings: _____

Doctor's Recommendations:

1. The applicant is ☐ fit / ☐ unfit for admission to day/residential care service.
   (No evidence of infectious disease or significant physical condition contraindicating placement into a group environment.)
2. The applicant should be referred to the following specialist for follow up examination:

   _____

Doctor's Signature: _____ Hospital/Clinic: _____

Name in block letter: _____ Tel.: _____

Date: _____ Ref. No.: _____

Remark: 1. This medical examination form is valid for 6 months from the date of issue.
2. Medical examination primarily serves the purpose of formulating individual care plan rather than screening. Flexibility should be applied whenever necessary.

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Reminder to Referrer

From: Central Referral System for Rehabilitation Services
Subsystem for Persons with Intellectual/Physical Disabilities
Social Welfare Department
6/F, West Coast International Building
290-296 Un Chau Street, Sham Shui Po, Kowloon

To:

CRSRehab-IPD Tel.:	3586 3809 / 3586 3826	Your Ref.:
Fax:	3755 4946	Your Tel:
Date:		Your Fax:

Name of applicant:

HKIC No.:

CRSRehab No.:

Name of Rehabilitation Unit:

Date of Selection:

CRSRehab-IPD has not received your reply to the placement offer for the above-named applicant. I would be grateful if you would reply to CRSRehab-IPD via *Form 7* **within 2 week(s)**. Otherwise, the applicant would be removed from the waiting list.

If you have already replied to this, I would much appreciate if you would forward a copy of *Form 7* to CRSRehab-IPD.

( )
Oi/c CRSRehab-IPD

c.c. Agency Head

RESTRICTED

Reminder to Referrer (for Annual Case Review)

From: Central Referral System for Rehabilitation Services
Subsystem for Persons with Intellectual/Physical Disabilities
Social Welfare Department
6/F, West Coast International Building
290-296 Un Chau Street, Sham Shui Po, Kowloon

To:

CRSRehab-IPD Tel.: 3422 3995 Your Ref.:
Fax: 3755 4946 Your Tel:
Date: Your Fax:

Name of Applicant:

HKIC No.:

CRSRehab No.:

Date of Application:

The above-named applicant has been registered on the Inactive Waiting List since _____. Please review the applicant's current condition and see if he/she would like to remain in the Inactive Waiting List. Otherwise, please reactivate his/her application and put him/her back to the Active Waiting List. Please reply to CRSRehab-IPD via *Form 3* **within 3 weeks**.

( )
Oi/c CRSRehab-IPD

RESTRICTED

Referral for Admission

From: Central Referral System for Rehabilitation Services
Subsystem for Persons with Intellectual/Physical Disabilities
Social Welfare Department
6/F, West Coast International Building
290-296 Un Chau Street, Sham Shui Po, Kowloon

To:

CRSRehab-IPD Tel.: 3586 3809 / 3586 3826 Your Ref.:
Fax: 3755 4946 Your Fax:
Date:

Referral for Admission to

_____

I forward the referral papers listed below of the following applicant for admission to your centre.

Please kindly reply by completing the *Report on Case Intake/Discharge (Form 9)* within 28 day(s).

By copy of this, the referrer is requested to contact the rehabilitation unit for case intake.

Case particulars:

Name of applicant: Hong Kong Identity Card:
Gender / D.O.B.: CRSRehab No.:

Referral papers attached:

1. Form 1
2. Psychological Report
3. Case Summary
4. Medical Report

( )
Oi/c CRSRehab-IPD

c.c. Referring office (without enclosure):
(Fax no.:)
(case ref.)

Report on Case Intake / Discharge

From: _____
(Name of Rehabilitation Unit)

_____
(Address of Organization)

Tel.: _____ Fax: _____

Date: _____

To: Central Referral System for Rehabilitation Services
Subsystem for Persons with Intellectual/Physical Disabilities
Social Welfare Department
6/F, West Coast International Building
290-296 Un Chau Street, Sham Shui Po, Kowloon

3586 3809 (DAC/HSMH/C&A/SD)
Tel.: 3586 3826 (SW/IVRSC/SHOS/HMMH/HSPH) Fax: 3755 4946

1. Case information

Name: _____ HKIC No.: _____ CRSRehab No.: _____

2. Please be informed that the above-named case has been:

☐ admitted into service on _____ *(date)*.

☐ unable to be admitted into service as there is no vacancy.

☐ found not suitable for the service upon re-assessment by the referrer under Standardised Assessment Mechanism, the original *Form 1* and relevant documents are attached.

☐ Rejected upon case screening due to:

- ☐ fail in job test
- ☐ low ability / motivation for training
- ☐ health problem (please specify): _____
- ☐ severely behavioral problem (please specify): _____
- ☐ others (please specify): _____

☐ self-withdrawn by applicant upon admission due to:

- ☐ open employment
- ☐ Supported Employment Training for Persons with Disabilities
- ☐ unfavourable location
- ☐ lost contact
- ☐ living in private / self-financing home
- ☐ prefer to live with / cared by family member(s)
- ☐ attending special school at present
- ☐ applicant / family members do not disclose any reason
- ☐ others (please specify): _____

☐ discharged from our service on _____ *(date)* due to the following reason:

- ☐ admitted to another day / residential care service of the same type
- ☐ admitted to other type of day / residential care service due to improvement of ability, pl. specify:___
- ☐ admitted to other type of day / residential care service due to deterioration, pl. specify: _____
- ☐ admitted to hospital (including psychiatric hospital) for more than 2 months
- ☐ admitted infirmary
- ☐ return home or family union
- ☐ compassionate rehousing or independent living
- ☐ deceased
- ☐ others (please specify): _____

Signature: _____ Name: _____ Post: _____

c.c. Referring office: _____

(case ref. _____)

Reminder to Rehabilitation Unit

From: Central Referral System for Rehabilitation Services
Subsystem for Persons with Intellectual/Physical Disabilities
Social Welfare Department
6/F, West Coast International Building
290-296 Un Chau Street, Sham Shui Po, Kowloon

To:

CRSRehab-IPD Tel.: 3586 3809 / 3586 3826 Your Ref.:
Fax: 3755 4946 Your Fax:
Date:

The following application(s) has/ have been referred to your unit for consideration of admission for more than 4 week(s). So far, no reply has been received by CRSRehab. I would be grateful for your prompt decision on this/ these application(s) and reply to CRSRehab via *Form 9* with a copy to the referrer concerned **within 2 week(s)**.

Date of Referral	CRSRehab No.	Name of Applicant	Gender	Age

( )
Oi/c CRSRehab-IPD

c.c. Agency Head
Referrer:

Application for Priority Placement

From: _____
(Name of Referring Office)

_____
(Name of Organization)

_____
(Address of Referring Office)

Ref.: _____

Tel.: _____

Fax: _____

Date: _____

To: Central Referral System for Rehabilitation Services
Subsystem for Persons with Intellectual/Physical Disabilities
Social Welfare Department
6/F, West Coast International Building
290-296 Un Chau Street
Sham Shui Po, Kowloon

3586 3809 (DAC/HSMH/C&A/SD)
Tel.: 3586 3826 (SW/IVRSC/SHOS/HMMH/HSPH)

Fax: 3755 4946

1. Case Particulars

Name: _____ Sex/D.O.B.: _____ HKIC No.: _____

Residential address: _____

Placement required: _____ CRSRehab No.: _____

2. Family Particulars

Name	Relationship	Sex/Age	Occupation/ Schooling	Income/ School fee	Disability/ Illness (if any)	Whether Living with Applicant (✓ or X)

3. Case/Family background

_____

_____

_____

_____

_____

4. Description of applicant's disabilities, assessment and treatment given, and recommendation made by relevant professional(s). Relevant report(s) is/are/not attached (please delete where inappropriate).

_____

_____

_____

_____

SWD 655A

5. Welfare service(s) received/receiving by applicant

Month/Year	Name of Service Centre	Type of Service	Reason(s) for Discharge

6. Challenging behaviour, including (please select whichever appropriate):

- ☐ Offensive behaviour e.g. screaming, regurgitating, noisy behaviour, smearing with faeces or any similar offensive or antisocial habits, etc.
- ☐ Self-abusive behaviour e.g. biting self, eye-poking, scratching self, picking at sores, slapping self or similar behaviours resulting in self harm, etc.
- ☐ Aggression toward others, i.e. causing bodily harm in others (with or without weapon)
- ☐ Destructive behaviour, i.e. causing damage to furniture, fittings, buildings, vehicles, etc.
- ☐ Inappropriate sexual behaviour e.g. exposes self, masturbates or groping others in public, etc.
- ☐ Repetitive behaviour e.g. rocking of body back and forth, flapping hands, flicking fingers, pacing up and down, constant running, or other stereotyped behaviours, etc.

Please provide a detailed description on the behaviour, the context where it happened, its severity and frequency, treatment made and whether any improvement is observed.

7. Present accommodation arrangement and description of home living environment.

8. Any deterioration in carer's physical/mental health condition, and his/her present capability to look after applicant.

9. Whether applicant is exposed to any physical/moral danger, and what kind of intervention is made.

_____

_____

_____

_____

_____

10. Reason(s) for priority placement (for priority placement in residential care service, justification for not staying in present accommodation should also be provided).

_____

_____

_____

_____

_____

_____

Recommended by

Signature: _____ Post Title: _____

Name: _____ Date: _____

11. Comment by Supporting Officer:

_____

_____

_____

_____

_____

Supported by*

Signature: _____ Tel.: _____

Name: _____ Fax: _____

Post Title: _____ Date: _____

* Support should be obtained from agency head/designated representative of non-governmental organization, principal of special school, or DSWO/ADSWO of SWD.

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Outcome of Application for Priority Placement

From: Central Referral System for Rehabilitation Services
Subsystem for Persons with Intellectual/Physical Disabilities
Social Welfare Department
6/F, West Coast International Building
290-296 Un Chau Street, Sham Shui Po, Kowloon

To:

CRSRehab-IPD Tel.:	3586 3809 / 3586 3826	Your Ref.:	
Fax:	3755 4946	Your Tel:	
Date:		Your Fax:	

Name of applicant:

HKIC No.:

CRSRehab No.:

☐ I am pleased to inform you that your application for priority placement for the above-named applicant is approved. The details of the placement are detailed below:

Type of Placement:

Date of Priority Assigned:

Location preference:

☐ The captioned application for priority placement is not approved or not necessary due to the following reason:

If you have any question, please contact the staff-on-duty at 3586 3809 or 3586 3826 for discussion on the case.

( )
Oi/c CRSRehab-IPD

Forms of the Subsystem for Persons in Mental Recovery (CRSRehab-PMR)

RESTRICTED

CENTRAL REFERRAL SYSTEM FOR REHABILITATION SERVICES
SUBSYSTEM FOR PERSONS IN MENTAL RECOVERY (CRSRehab-PMR)
REGISTRATION FORM

Name of Applicant: _____
(This part should be completed for facsimile purpose)

Instruction: Please use BLOCK LETTERS to fill the information or give a '√' in the boxes, whichever is required.

Part A

A. Source of Referral

Case reference no. _____

Name of referrer _____ Signature _____

Office / Centre _____

Tel. no. _____ Fax no. _____ Date _____

B. Personal Particulars

1. Name of applicant: _____ ( )
2. HKIC No.: _____
3. Date of birth: ____ / ____ / ____ (DD/MM/YYYY) 4. Sex: _____
5. Residential district: _____
6. Whether the client is living in institution or hospital? ☐No ☐Yes Since (DD/MM/YYYY / /
   Name of institution or hospital: _____
7. Medical History:
   Psychiatric diagnosis: _____
   Onset of mental illness in: _____ (YYYY)
   Other illness, please specify: _____
   ☐A. Conditional discharge / ☐B. Unconditional discharge
   ☐A. Intensive care case / ☐B. Non-intensive care case
   ☐B.1. Special care case
   ☐B.2. Conventional care case
   ☐C. Ex-intensive care case
   ☐A. Yes ☐N. No
   Other medical history ☐A. Anti-social behavior ☐B. Suicidal tendency
   ☐C. Drug addiction ☐D. Alcoholism
   ☐E. Sexual deviation ☐F. Others _____
8. Whether the case has been consulted with the case medical officer? ☐ Yes or ☐ No
9. Other conditions
   Ex-offender ☐N. No ☐A. Yes, with imprisonment ☐B. Yes, without imprisonment
   Member of Triad Society ☐N. No ☐A. Yes

C. Particular of placement required

1. Day Placement *(please select by ticking one type of day placements only)*

Code	*Service Type*	*Location Preference 1*	*Location Preference 2*	*Location Preference 3*
B ☐	Sheltered Workshop / Integrated Vocational Rehabilitation Service Centres			

2. Residential Placement *(please select by ticking one type of residential placements only)*

Code	*Service Type*	*Location Preference 1*	*Location Preference 2*	*Location Preference 3*
C ☐	Halfway house [Subvented]			
L ☐	Halfway house [Subvented + Bought Place Scheme for Private Residential Care Homes for Persons with Disabilities]			
E ☐	Halfway house with special provision (previously known as Purpose-built Halfway House)			
G ☐	Long Stay Care Home [Subvented]			
H ☐	Long Stay Care Home [Subvented + Bought Place Scheme for Private Residential Care Homes for Persons with Disabilities]			
I ☐	Supported Hostel [Subvented]			
N ☐	Supported Hostel [Subvented + Bought Place Scheme for Private Residential Care Homes for Persons with Disabilities]			

D. Priority Placement

Whether the client is in need of priority placement? ☐N. No ☐ A. Yes (If yes, please give reason)

1. For referring units serving dischargees of correctional institutes, i.e. Siu Lam Psychiatric Centre and other prisons, please input the reasons for priority placement here. _____

_____

2. For other referring units, please submit Form 1 together with Form 10 for the application in need of priority placement.

E. Declaration

☐ Referrer has declared that there is no conflict of interest in handling this application. Referrer is not a family member or personal friend of the applicant and has no personal or social ties with the applicant, and she/he has notified the applicant/family member(s)/guardian/carer(s) that SWD and the referring agency will not charge for the application and referral for service. The applicant/family member(s)/guardian/carer(s) should report to the Independent Commission Against Corruption (ICAC) immediately in case anyone offers to assist in application for placement in return for remuneration. Attempted bribery by any person is also an offence in law, SWD will refer the case to ICAC for investigation.

Endorsed by:	Prepared by:
Signature: _____	Signature: _____
Name: _____	Name: _____
Designation: _____	Designation: _____
Office: _____	Office: _____
Date: _____	Date: _____

RESTRICTED

Confirmation of Registration

From: Central Referral System for Rehabilitation Services
Subsystem for Persons in Mental Recovery
Social Welfare Department
Room 901, 9/F Wu Chung House
213 Queen's Road East, Wanchai, Hong Kong

To:

The following applicant has been registered in CRSRehab-PMR for rehabilitation service. Please kindly verify the following data, raise amendment and update any subsequent change to CRSRehab-PMR by Form 3. For case enquiries, please contact the staff-on-duty at 2892 5134 / 2892 5347. For data protection, only enquiries from the referrer will be answered.

I. Information of referrer

Tel No.: Fax No.:

II. Case particulars

Name: 姓名:
Sex: HKIC:
D.O.B.: Res. District.:
Ref. No.: CRSRehab No.:
Registered: Last Update:

Medical History
Living in institution: Hospital:
Date of admission:
Psychi. Diagnosis: Onset date:
Other illness: Other history:
Conditional discharge:
Intensive care case:
Other condition
Ex-offender: Imprisonment:
Triad society member:

III. Day Placement required (application date) **Res. Placement required (application date)**

Status of day service: Status of res. service:
Offer at the same time:

IV. Status of application Priority (day/residential) : Normal / Normal

Name: _____
Post: Oi/c CRSRehab - PMR
Date of issue: _____

限閱文件
RESTRICTED

社會福利署
康復服務中央轉介系統
申請康復服務登記書
Notification of Registration for Rehabilitation Services
Central Referral System for Rehabilitation Services
Social Welfare Department

/ / 20

致： 康復服務申請人（經個案社工／轉介者轉交）
To: Applicant (Via Caseworker/Referrer)

下列申請經已於社會福利署（社署）康復服務中央轉介系統內登記，詳情如下：
The following application has been registered in the Central Referral System for Rehabilitation Services of the Social Welfare Department (SWD) with details listed as below:

姓名：
Name: _____
香港身份證：
Hong Kong Identity Card: _____
申請日期：
Date of Application: _____
申請輪候的康復服務：
Rehabilitation Service(s) Applying for: _____
輪候狀況：
Status on Waiting List: _____
檔案號碼：
Your Reference: _____
申請人編號：
CRSRehab No.: _____
服務地區選擇：
Location Preference: _____

倘若你獲得編配所申請的服務，康復服務中央轉介系統將會透過你的社工／轉介者與你聯絡，安排接受有關服務。為令各方面保持緊密聯絡，若果你的聯絡地址、電話或所需的服務已轉變，請儘快通知個案社工／轉介者，以便他／她將有關資料轉達本系統。就上述服務的申請及轉介事宜，社署及轉介機構不會收取任何費用。若有人藉詞協助申請而索取利益，申請人應立即向廉政公署舉報。任何人意圖行賄，亦屬違法，社署會將個案轉介廉政公署查究。

Once you are selected for a placement in rehabilitation unit, the Central Referral System for Rehabilitation Services will inform you via the referring social worker to prepare for acceptance of placement offer. For maintaining good contacts among all parties concerned, please inform the referring social worker as early as possible if you have changes in your address, telephone number or rehabilitation services required, so that information may be updated at the Central Referral System for Rehabilitation Services. SWD and the referring agency will not charge for the application and referral for service. The applicant should report to the Independent Commission Against Corruption (ICAC) immediately in case anyone offers to assist in application for placement in return for remuneration. Attempted bribery by any person is also an offence in law, SWD will refer the case to ICAC for investigation.

如你對以上的申請有任何查詢，請與你的社工／轉介者聯絡：
Should you have any enquiry on the above application, you may contact your referring social worker:

社工／轉介者姓名：
Caseworker / Referrer Name: _____
機構名稱：
Centre: _____
辦公室地址：
Office Address: _____
聯絡電話（內線）：
Phone Contact No. (ext.): _____

CENTRAL REFERRAL SYSTEM FOR REHABILITATION SERVICES
SUBSYSTEM FOR PERSONS IN MENTAL RECOVERY (CRSRehab-PMR)
Application for Transfer to Other Residential Care Unit for Persons with Disabilities Under Same Service Type

Name of Applicant: _____
(This part should be completed for facsimile purpose)

Instruction: Please use BLOCK LETTERS to fill the information or give a '√' in the boxes, whichever is required.

Part A

A. Source of Referral

Case reference no. _____

Name of referrer _____ Signature _____

Office / Centre _____

Tel. no. _____ Fax no. _____ Date _____

B. Personal Particulars

1. Name of applicant: _____ ( )
2. HKIC No.: _____
3. Date of birth: _____ / _____ / _____ (DD/MM/YYYY) 4. Sex: _____
5. Name of Residential Unit: _____
6. Date of Admission: ____ / _____ / _____ (DD/MM/YYYY)
7. Whether the client is living in institution or hospital? ☐No, ☐Yes Since (DD/MM/YYYY) __ / __ / ____
   Name of institution or hospital: _____
8. Medical History:
   Psychiatric diagnosis: _____
   Onset of mental illness in: _____ (YYYY)
   Other illness, please specify: _____
   ☐A. Conditional discharge / ☐B. Unconditional discharge
   ☐A. Intensive care case / ☐B. Non-intensive care case
   ☐B.1. Special care case
   ☐B.2. Conventional care case
   ☐C. Ex-intensive care case
   ☐A. Yes ☐N. No
   Other medical history ☐A. Anti-social behavior ☐B. Suicidal tendency
   ☐C. Drug addiction ☐D. Alcoholism
   ☐E. Sexual deviation ☐F. Others _____
9. Whether the case has been consulted with the case medical officer? ☐ Yes or ☐ No
10. Other conditions
    Ex-offender ☐N. No ☐A. Yes, with imprisonment ☐B. Yes, without imprisonment
    Member of Triad Society ☐N. No ☐A. Yes

C. Particular of placement required

1. *(please tick the same type of residential placement that the applicant currently resides and indicate the location preference if necessary)*

Code	*Service Type*	*Location Preference 1*	*Location Preference 2*	*Location Preference 3*
C ☐	Halfway house [Subvented]			
L ☐	Halfway house [Subvented + Bought Place Scheme for Private Residential Care Homes for Persons with Disabilities]			
E ☐	Halfway house with special provision (previously known as Purpose-built Halfway House)			
G ☐	Long Stay Care Home [Subvented]			
H ☐	Long Stay Care Home [Subvented + Bought Place Scheme for Private Residential Care Homes for Persons with Disabilities]			
I ☐	Supported Hostel [Subvented]			
N ☐	Supported Hostel [Subvented + Bought Place Scheme for Private Residential Care Homes for Persons with Disabilities]			

D. Reason(s) of Application for Transfer

Please state the reasons for the application for transfer (supplemented with other supporting document if necessary).

_____

_____

_____

_____

_____

E. Declaration

☐ Referrer has declared that there is no conflict of interest in handling this application. Referrer is not a family member or personal friend of the applicant and has no personal or social ties with the applicant, and she/he has notified the applicant/family member(s)/guardian/carer(s) that SWD and the referring agency will not charge for the application and referral for service. The applicant/family member(s)/guardian/carer(s) should report to the Independent Commission Against Corruption (ICAC) immediately in case anyone offers to assist in application for placement in return for remuneration. Attempted bribery by any person is also an offence in law, SWD will refer the case to ICAC for investigation.

Endorsed by*:		Prepared by:	
Signature:	_____	Signature:	_____
Name:	_____	Name:	_____
Designation:	_____	Designation:	_____
Office:	_____	Office:	_____
Date:	_____	Date:	_____

* Endorsement should be obtained from agency head/designated representative of non-governmental organisation or DSWO/ADSWO of SWD.

RESTRICTED

Outcome of Application for Transfer to Other Residential Care Unit for Persons with Disabilities Under Same Service Type

From: Central Referral System for Rehabilitation Services
Subsystem for Persons in Mental Recovery
Social Welfare Department
Room 901, 9/F Wu Chung House
213 Queen's Road East, Wanchai, Hong Kong

To:

CRSRehab Tel.:
Fax:
Date:

Your Ref.:
Your Tel:
Your Fax:

Name:

HKIC:

CRSRehab No.:

The application for transfer to other residential care unit under same service type of the above-named has been received.

☐ Applicant has been **put back to the active waiting list**. The application date of residential care service on _____ is retained.

☐ The application is considered not justified and hence not approved. Should there is any change in circumstances in future warranting application for transfer, applicant may make a fresh application again.

( )
Oi/c CRSRehab-PMR

From:	To:

Standard Agency Application Form

(This part should be completed by the referrer) [RESTRICTED]

Total no. of pages included: ( ) page 1☑ page 2☑ page 3☐ page 4☐ (please ☑ as appropriate)

Name of applicant: _____ (____) : _____ Sex / Age: ____ / _____
D.O.B.: ____/____/____(DD/MM/YYYY) CRSRehab no.: _____ Hospital/Clinic ref. no.: _____
Service required: _____

Part I Applicant's Information (to be completed by Referrer)

Place of birth: _____ Spoken language: _____ Year arrived at HK: _____
Marital status: ☐ Single / ☐ Married / ☐ Divorced / ☐ Separated / ☐ Widowed
Address & Tel.: _____ (_____)
Type of accommodation: ☐ Hut / ☐ Cubicle / ☐ Bed-spacer / ☐ Room / ☐ Flat ☐ Others: _____
Name of carer: _____ Relationship with applicant: _____
Contact address & Tel.: _____ (_____)
Education level: _____
Financial support: ☐ CSSA / ☐ SSA / ☐ Self-supporting / ☐ Others (please specify) _____

Particular of Family member / Close relatives (living together with applicant):

Name	Relationship	Sex / Age	Occupation	Level of support #
		/		
		/		
		/		
		/		

 # Level of support to the applicant: Rejecting, Indifferent, Supportive, Overprotective.

Recent occupational record: e.g. Open employment / Sheltered workshop / Supported Employment Training for Persons with Disabilities(SET) etc.

Duration	Post / Title	Salary	Reason for leaving the job
to			
to			

Social welfare services waitlisted: e.g. Halfway house / Hostel / Sheltered workshop / Supported Employment Training for Persons with Disabilities(SET)etc.

Date of referral made	Service requested	Referring organization	Remarks

Undesirable habits: Anti-social behavior / Drug addiction / Alcoholism / Heavy smoking / Gambling etc. if any please specify:-

Reason for referral: _____

Name of referrer (in BLOCK): _____ (Signature): _____
Office / Centre: _____ Organisation: _____
Telephone no.: _____ ext.: _____ Fax no.: _____
Date: _____

From:	To:

Standard Agency Application Form

(This part should be completed by the referrer) [RESTRICTED]

Name of applicant: _____ (____) HKID: _____ Sex / Age: ____ / _____
D.O.B.: ____ / ____ / ____ (DD/MM/YYYY) CRSRehab no.: _____ Hospital/Clinic ref. no.: _____
Hospital / Clinic: _____ Ward: _____

Part II Medical history (to be completed by case medical officer)

Diagnosis: _____
Case nature: Intensive care case / Special care case / Conventional case */ Others:
Ex-Intensive Care Case: ☐ Yes ☐ No (Please tick)
Intelligence: Normal / Borderline / Mild / Moderate / Severe* IQ Score: _____ (if available)
Date of assessment: _____
Premorbid personality: _____
Relevant medical illness(es) or disability(s): _____
Date of onset of mental illness: _____ Total no. of admissions:
Reason(s) for present hospitalization: _____

Dates of last three admissions: (include the present admission)

Duration	Name of hospital	Diagnosis	Voluntary / Compulsory
to			
to			
to			

Symptoms at present attack: _____
Anti-social behavior: _____ Prognosis:

☐ Problem drinking ☐ Drug addiction Maintenance treatment:
☐ Problem gambling ☐ Others: _____ (include medication) _____
☐ Criminal record (Details: _____) Response to treatment: _____
Suicidal tendency: _____ history: _____
History of violence / aggressiveness: _____
Nature of violent / aggressive behavior: _____
Outcome / Sentence: _____
Predisposing factors to violence: _____
Psychological / Social / Biological * (please specify) _____
Free from violent / aggressive behavior in the last _____ months / years *
Is applicant a conditionally discharged case? ☐ Yes ☐ No
The applicant ☐ is / ☐ is not recommended to receive the service applied:

Additional remarks : (supplementary sheet if required, e.g. insight into mental illness)

Referring CMO: (Signature) _____ Name in BLOCK: _____
Tel. no.: _____ ext: _____ Date: _____

please delete as appropriate.

From:	To:

Standard Agency Application Form

(This part should be completed by the referrer) [RESTRICTED]

Name of applicant: _____ (____) HKID: _____ Sex / Age: ____ / _____
D.O.B.: ____ / ____ / ____ (DD/MM/YYYY) CRSRehab no.: _____ Hospital/Clinic ref. no.: _____
Hospital / Clinic: _____ Ward: _____

Part III Nursing report (to be completed by ward nurse) ***Please tick as appropriate***

					Remarks
A.	Personal hygiene:	1.	Reluctant to perform self-care like bathing or changing underwear	☐	●
		2.	Need prompting	☐	
		3.	Able to look after personal hygiene independently	☐	
B.	Cooperation in ward life:	1.	Not willing to do his share	☐	●
		2.	Willing to do his share but no more	☐	
		3.	Willing to do more than his share	☐	
C.	Drug compliance:	1.	Shows strong reluctance even being prompted	☐	●
		2.	Take medication when being advised	☐	
		3.	Take medication on his own initiative	☐	
D.	Social mixing / Ward life:	1.	Withdraws from social mixing	☐	●
		2.	Mixes with other in organized groups only	☐	
		3.	Mixes with others spontaneously	☐	
E.	Attitude towards placement:	1.	Resists the idea	☐	●
		2.	Will do whatever is suggested	☐	
		3.	Welcomes the idea	☐	
F.	Money management:	1.	Spends appropriately	☐	●
		2.	Reluctant to spend	☐	
		3.	Fails to keep money	☐	
G.	Nursing care dependency:	1.	Intensive nursing care needed	☐	●
		2.	Medium level of nursing care needed	☐	
		3.	Minimum nursing care needed	☐	

H. Overall comment:

_____

_____

I. Other remarks: _____

_____

_____

Referring nurse: (Signature) _____ Name in BLOCK: _____
Tel. no.: _____ ext: _____ Ward: _____ Date: _____

From:	To:

Standard Agency Application Form

(This part should be completed by the referrer) [RESTRICTED]

Name of applicant: _____ (____) HKID: _____ Sex / Age: ____ / _____
D.O.B.: ____/____/____ (DD/MM/YYYY) CRSRehab no.: _____ Hospital/Clinic ref. no.: _____
Hospital / Clinic: _____ Ward: _____

Part IV Occupational therapy record (to be completed by occupational therapist)

General performance *(please ✓ as appropriate)*

		V. Good	Good	Fair	Poor
A.	***Household management skills***				
	Meal preparation skills	☐	☐	☐	☐
	Laundry	☐	☐	☐	☐
	Household cleansing	☐	☐	☐	☐
	Home safety	☐	☐	☐	☐
B.	***Community living***				
	Use of community resources	☐	☐	☐	☐
	Use of transportation	☐	☐	☐	☐
	Road safety	☐	☐	☐	☐
	Money management	☐	☐	☐	☐
C.	***Work performance***				
	Attendance	☐	☐	☐	☐
	Punctuality	☐	☐	☐	☐
	Concentration	☐	☐	☐	☐
	Following instructions	☐	☐	☐	☐
	Work motivation	☐	☐	☐	☐
	Work tolerance and endurance	☐	☐	☐	☐
	Work skills	☐	☐	☐	☐
D.	***Social behavior***				
	Cleanliness / Appearance	☐	☐	☐	☐
	Getting along with others	☐	☐	☐	☐
	Cooperation	☐	☐	☐	☐

Special vocational skill / interest:

In view of the applicant's employment record and present work capability, the applicants work potential can reach :
☐Sheltered workshop/ ☐ Supported Employment Training for Persons with Disabilities(SET)/ ☐Part-time employment/ ☐Full-time employment.

Other remarks: _____

Referring OT: (Signature) _____ Name in BLOCK: _____
Tel. no.: _____ ext: _____ Ward / Team / Unit: _____ Date: _____

RESTRICTED

Data Updating Form

From:	_____ *(Name of Referring Office)* _____ *(Name of Organisation)*	To:	Central Referral System for Rehabilitation Services Subsystem for Persons in Mental Recovery Social Welfare Department Room 901, 9/F Wu Chung House 213 Queen's Road East, Wanchai, Hong Kong
Ref.:		Your Ref.:	
Tel.:		Tel.:	2892 5136
Fax:		Fax:	2893 6983
Date:			

Name of applicant: _____ HKIC No.: _____ CRSRehab No.: _____

Information to be updated: (✓ in the appropriate box)

- ☐ Day placement is no longer required. (Case will be removed from Day placement waiting list)
- ☐ Residential placement is no longer required. (Case will be removed from Residential placement waiting list)

- ☐ Update in placement request:
  Day placement: ☐ Sheltered Workshop/ Integrated Vocational Rehabilitation Services Centre
  Residential placement:
  ☐ SHOS (Subvented) ☐ SHOS (Subvented + BPS*)
  ☐ HWH (Subvented) ☐ HWH (Subvented + BPS*) ☐ HWH(SP)
  ☐ LSCH (Subvented) ☐ LSCH (Subvented + BPS*)

- ☐ Change in location preference:
  ☐ Day placement:
  -
  -
  -
  ☐ Residential placement:
  -
  -
  -

- ☐ Change in referring office #: *(New office name)* _____

- ☐ Change in referrer #: *(New referrer name)* _____
  (Phone number) _____ *(Fax number)* _____

- ☐ Change in applicant's personal particulars (residential district, disability, etc.): _____

- ☐ Update status in Special Care System:
  ☐ Intensive care case
  ☐ Non-intensive care case (Special / Conventional care case)

- ☐ Others, please specify: _____

Signature: _____

Name: *(in block letter)* _____

Post: _____

*BPS = Bought Place Scheme for Private Residential Care Homes for Persons with Disabilities

c.c. New referrer (Fax: _____)

RESTRICTED

Removal from Waiting List

From: Central Referral System for Rehabilitation Services
Subsystem for Persons in Mental Recovery
Social Welfare Department
Room 901, 9/F Wu Chung House
213 Queen's Road East, Wanchai, Hong Kong

To:

CRSRehab Tel.: Your Ref.:
Fax: Your Tel:
Date: Your Fax:

Name:

HKIC:

CRSRehab No.:

The above-named application has been removed from the waiting list due to the following reason:

☐ Case closed in CRSRehab-PMR upon:

☐ Hospitalisation of applicant. Please refer to the *Manual of Procedures* for CRSRehab for further information.

☐ Applicant being rejected twice by different agencies in the same service. Please arrange for re-assessment in the applicant's genuine service need.

( )
Oi/c CRSRehab - PMR

Report of Vacancies

From:	_____ *(Name of Rehabilitation Unit)*	To:	Central Referral System for Rehabilitation Services
	_____ *(Name of Organization)*		Subsystem for Persons in Mental Recovery
Ref.:	_____		Room 901, 9/F Wu Chung House
Tel.:	_____		213 Queen's Road East
Fax:	_____		Wanchai, Hong Kong
Date:	_____	Tel.:	2892 5136
		Fax:	2893 6983

1. Number of vacancies as at _____ / _____ / _____ (*DD/MM/YYYY*)

Service	LSCH / HWH / SHOS *		HWH - SP	
Sex	M	F	M	F
(a) Capacity				
(b) Enrolment				
(c) No. of referral(s) approved and pending admission				
(d) No. of referral(s) being processed				
(e) No. of immediate vacancy [(e) = (a) – (b) – (c) – (d)]				
Remarks				

2. Number of vacancies anticipated in forthcoming 2 months (excluding those reported in item 1):

Service	LSCH / HWH / SHOS *		HWH - SP	
Sex	M	F	M	F
Vacancies				
Available date(s)				
Remarks				

* Please delete as appropriate

Signature: _____

Name: _____

Post: _____

RESTRICTED

Selection for Placement

From: Central Referral System for Rehabilitation Services
Subsystem for Persons in Mental Recovery
Social Welfare Department
Room 901, 9/F Wu Chung House
213 Queen's Road East, Wanchai, Hong Kong

To:

CRSRehab Tel.:	Your Ref.:
Fax:	Your Tel:
Date:	Your Fax:

The following applicant has been selected to the placement in a rehabilitation unit with details shown below. Please reply to CRSRehab via *Form 7* **within week(s)**.

Your early reply will facilitate the applicant's admission for service. You may consider contacting the rehabilitation unit for arrangement of visits for the applicant or information on the service as appropriate. (For priority placement, please review and confirm the applicant still has urgent service need.)

Name of applicant:

CRSRehab No.:

Name of Rehabilitation Unit:

Type of Service:

Address:

Tel. No.:

Fax No.:

Date of Selection:

If the applicant accepts the placement offer, please send the following required documents to the rehabilitation unit directly:

1. Standard Agency Application Form (CRSRehab-PMR Form 2)

( )
Oi/c CRSRehab - PMR

RESTRICTED

Notification of Case Selection to Rehabilitation Unit

From: Central Referral System for Rehabilitation Services
Subsystem for Persons in Mental Recovery
Social Welfare Department
Room 901, 9/F Wu Chung House
213 Queen's Road East, Wanchai, Hong Kong

To:

CRSRehab Tel.: Your Tel:
Fax: Your Fax:
Date:

Listed below for your information are the application(s) that have been selected from the waiting list for placement in your service unit. These applicants have 14 day(s)' time to decide whether they accept the placement offer or not. Subject to their acceptance of placement offer, the referrer will send relevant documents to you for case intake once they are available.

While the applicants are considering acceptance of placement offer, they and/or their family members may, through the referring officers, approach your unit for visits or information on services provided.

Since some of the applicants may eventually decline the placement offer, if you need updated referral situation of the list, please contact the undersigned officer of the CRSRehab.

Name	Sex/ Age	CRSRehab No.	Referring Office	Name of Referrer	Tel	Normal/ Priority

Please be reminded that your staff should have declared that there is no conflict of interest in handling the application(s). They are not a family member or personal friend of the applicant and have no personal or social ties with the applicant.

( )
Oi/c CRSRehab - PMR

RESTRICTED

Reply to CRSRehab-PMR on Selection for Placement

From:	_____ *(Name of Referring Office)*	To:	Central Referral System for Rehabilitation Services Subsystem for Persons in Mental Recovery Social Welfare Department Room 901, 9/F Wu Chung House 213 Queen's Road East, Wanchai, Hong Kong
	_____ *(Name of Organisation)*		
Ref:	_____		
Tel:	_____		
Fax:	_____	Tel:	2892 5136
Date:	_____	Fax:	2893 6983

Application for placement to: _____
(name of rehabilitation unit)

Name of applicant: _____ HKIC No.: _____ CRSRehab No.: D _____

(✓ in the appropriate box)

☐ **Applicant accepts the offer.** (For priority placement, the applicant is confirmed to have urgent service need.)
The completed CRSRehab-PMR Form 2 have already been sent to the rehabilitation unit for further action on / / _____

☐ **Applicant declines the offer.** (The application will be removed from the concerned Day placement/ Residential placement waitlisting, please refer to CRSRehab Manual of Procedures)

- ☐ Unfavourable location
- ☐ Ill health / unstable mental or emotional condition
- ☐ Temporary leave of Hong Kong / emigration
- ☐ Open employment/ Supported Employment Training for Persons with Disabilities
- ☐ Lost trace of applicant
- ☐ No longer in need of placement upon case review
- ☐ Ability improved, upward movement required
- ☐ Ability deteriorated, downward movement required
- ☐ Self-withdrawal/ unmotivated / unwillingness
- ☐ Already receiving day programme in rehabilitation unit (please specify):
  Name of unit: _____
  Admission date: _____
- ☐ Others, please specify: _____

For case declining BPS offer, please tick below box if residential service is no longer required

☐ (Case will be removed from waiting list directly)

☐ **Applicant is temporarily hospitalised.** (not applicable to the applicants who are admitted to psychiatric hospital or psychiatric ward of general hospital, please refer to CRSRehab Manual of Procedures)

Name of Hospital: _____
Admission date: _____
Diagnosis/Treatment required: _____

Signature: _____
Name: _____
Post: _____

c.c. Rehabilitation Unit ( ) Fax: ( )

RESTRICTED

FIRST Reminder to Referrer

From: Central Referral System for Rehabilitation Services
Subsystem for Persons in Mental Recovery
Social Welfare Department
Room 901, 9/F Wu Chung House
213 Queen's Road East, Wanchai, Hong Kong

To:

CRSRehab Tel.: Your Ref.:
Fax: Your Tel:
Date: Your Fax:

Name of applicant:

HKIC No.:

CRSRehab No.:

Name of Rehabilitation Unit:

Date of Selection:

CRSRehab has not received your reply to the placement offer for the above-named applicant. You are advised to send the required document(s) stated in Form 6 to the rehabilitation unit directly and reply to CRSRehab via *Form 7* **within 1 week**.

If you have already replied to this offer, it would be appreciated if you could forward a copy of Form 7 to CRSRehab again.

( )
Oi/c CRSRehab - PMR

c.c. Supervisor ( ) (Fax:)

RESTRICTED

SECOND Reminder to Referrer

From: Central Referral System for Rehabilitation Services
Subsystem for Persons in Mental Recovery
Social Welfare Department
Room 901, 9/F Wu Chung House
213 Queen's Road East, Wanchai, Hong Kong

To:

CRSRehab Tel.:
Fax:
Date:

Your Ref.:
Your Tel:
Your Fax:

Name of applicant:

HKIC No.:

CRSRehab No.:

Name of Rehabilitation Unit:

Date of Selection:

CRSRehab has not received your reply to the placement offer for the above-named applicant. You are advised to send the required document(s) stated in Form 6 to the rehabilitation unit directly and reply to CRSRehab via *Form 7* **within 1 week**.

If you have already replied to this offer, it would be appreciated if you could forward a copy of *Form 7* to CRSRehab again.

( )
Oi/c CRSRehab - PMR

c.c. Agency Head

RESTRICTED

Referral for Admission

From: Central Referral System for Rehabilitation Services
Subsystem for Persons in Mental Recovery
Social Welfare Department
Room 901, 9/F Wu Chung House
213 Queen's Road East, Wanchai, Hong Kong

To:

CRSRehab Tel.: Your Tel:
Fax: Your Fax:
Date:

Referral for Admission to

_____

I forward the following application for admission to your unit whereas the referrer has already sent you the CRSRehab-PMR Form 2. Please reply by completing the *Report on Case Intake/Discharge (Form 9)* within **2 week(s)**.

Case particulars:

Name of applicant: HKIC No.:
Sex: D.O.B.: CRSRehab No.:

( )
Oi/c CRSRehab - PMR

c.c. Referring office: (Fax no.:)

RESTRICTED

Report on Case Intake / Discharge

From:	_____ *(Name of Rehabilitation Unit)*	To:	Central Referral System for Rehabilitation Services Subsystem for Persons in Mental Recovery Social Welfare Department Room 901, 9/F Wu Chung House 213 Queen's Road East, Wanchai, Hong Kong
	_____ *(Name of Organisation)*		
Our Ref.:	_____		
Tel.:	_____	Your Ref.:	
Fax:	_____	Tel.:	2892 5136
Date:	_____	Fax:	2893 6983

Name of applicant: _____ HKIC No.: _____ CRSRehab No.: D _____

Please be informed the above-named case has been: (✓ in the appropriate box)

☐ **admitted** into service on _____ *(date)*.

☐ **rejected** upon intake assessment due to:

- ☐ no vacancy
- ☐ low ability / no motivation for training
- ☐ severe behavioral problem (please specify): _____
- ☐ unstable mental / emotional condition
- ☐ health problem (please specify):
- ☐ others (please specify):

☐ **self-withdrawn** by applicant due to:

- ☐ unfavourable location
- ☐ claim to have no day and / or residential service need
- ☐ the family member(s)' rejection of the placement offer
- ☐ prefer to live with family / take care by family member(s)
- ☐ open employment / Supported Employment Training for Persons with Disabilities (for sheltered workshop applicant only)
- ☐ refusal to give reason by the applicant / family member(s)
- ☐ others (please specify): _____
- ☐ refusal to attend pre-admission interview
- ☐ refusal to follow the regulation
- ☐ lost trace

☐ **reserved** due to no immediate vacancy but would be admitted within 1 month.
The admission is scheduled on _____ *(date)*

☐ **temporarily hospitalised**: (not applicable to the applicants who are admitted to psychiatric hospital or psychiatric ward of general hospital, please refer to CRSRehab Manual of Procedures):

Name of Hospital: _____
Admission date: _____
Diagnosis / Treatment required: _____

☐ **discharged** from our service on _____ *(date)* due to: _____

Signature: _____

Name: _____

Post: _____

c.c. Referring office

RESTRICTED

FIRST Reminder to Rehabilitation Unit

From: Central Referral System for Rehabilitation Services
Subsystem for Persons in Mental Recovery
Social Welfare Department
Room 901, 9/F Wu Chung House
213 Queen's Road East, Wanchai, Hong Kong

To:

CRSRehab Tel.: Your Tel:
Fax: Your Fax:
Date:

The following application(s) has/ have been referred to your unit for consideration of admission for more than 2 week(s). So far, no reply has been received by CRSRehab. I would be grateful for your prompt decision on this/ these application(s) and reply to CRSRehab via *Form 9* with a copy to the referrer concerned **within 1 week**.

Date of Referral	CRSRehab No.	Name of Applicant	Sex	D.O.B.

( )
Oi/c CRSRehab - PMR

c.c. Supervisor of Rehabilitation Unit (Fax:)

RESTRICTED

SECOND Reminder to Rehabilitation Unit

From: Central Referral System for Rehabilitation Services
Subsystem for Persons in Mental Recovery
Social Welfare Department
Room 901, 9/F Wu Chung House
213 Queen's Road East, Wanchai, Hong Kong

To:

CRSRehab Tel.: Your Tel:
Fax: Your Fax:
Date:

The following application(s) has/ have been referred to your unit for consideration of admission for more than 3 week(s). So far, no reply has been received by CRSRehab. I would be grateful for your prompt decision on this/ these application(s) and reply to CRSRehab via *Form 9* with a copy to the referrer concerned **within 1 week**.

Date of Referral	CRSRehab No.	Name of Applicant	Sex	D.O.B.

( )
Oi/c CRSRehab - PMR

c.c. Agency Head

RESTRICTED

Application for Priority Placement

From:	_____ *(Name of Referring Office)*	To:	Central Referral System for Rehabilitation Services Subsystem for Persons in Mental Recovery Social Welfare Department Room 901, 9/F Wu Chung House 213 Queen's Road East, Wanchai, Hong Kong
	_____ *(Name of Organisation)*		
Our Ref:	_____		
Tel:	_____		
Fax:	_____	Tel:	
Date:	_____	Fax:	

1. Case Particulars

Name: _____ Sex/D.O.B.: ____/____ ID No.: _____
Address: _____ Tel.: _____
Diagnosis: _____
Placement(s) required: _____ CRSRehab-PMR No.: _____

2. Reasons for priority application (Please attach additional sheet if required)

_____
_____
_____
_____
_____
_____

3. Preference in location if necessary:

☐ **No** ☐ **Yes (Preference is not encouraged unless absolutely necessary)**

Please specify location preference: _____ and give justifications below:

_____
_____
_____
_____

Prepared by:		Endorsed by*	
Signature:	_____	Signature:	_____
Name:	_____	Name:	_____
Post:	_____	Post:	_____

* Endorsement should be obtained from agency head/designated representative of non-governmental organisation or DSWO/ADSWO of SWD.

RESTRICTED

Outcome of Application for Priority Placement

From: Central Referral System for Rehabilitation Services
Subsystem for Persons in Mental Recovery
Social Welfare Department
Room 901, 9/F Wu Chung House
213 Queen's Road East, Wanchai, Hong Kong

To:

CRSRehab Tel.:
Fax:
Date:

Your Ref.:
Your Tel:
Your Fax:

Name of applicant:

HKIC:

CRSRehab No.:

☐ I am pleased to inform you that your application for priority placement for the above-named applicant is approved. The particulars of the placement are detailed below:

Type of Placement:

Date of Priority Assigned:

Location preference:

☐ The captioned application for priority placement is not approved or not necessary due to the following reason:

If you have any question, please contact the undersigned for discussion on the case.

( )
Oi/c CRSRehab – PMR

Forms of the Subsystem for Elderly Persons with Visual Impairment (CRSRehab-VI)

RESTRICTED

Central Referral System for Rehabilitation Services

Subsystem for Elderly Persons with Visual Impairment (CRSRehab-VI) Data Input Form

Only person aged 60 or above and is certified as **blindness** or with **severe vision impairment** is eligible to apply for Care and Attention Home for the Aged Blind.

Please use BLOCK LETTERS to fill in the information or give a '✓' in the boxes, whichever is required.

PART A Applicant's Personal Information

1. Name of Applicant: _____ ( )
   (In English, Surname first) (In Chinese)

2. HKID No.: _____ ( ) *or*

   Certificate of Exemption : L/M ( ) in RP 3/3/220/( )

3. Date of Birth : / /
   Day Month Year

4. Sex: ☐ Male ☐ Female

5. Marital Status:
   ☐ Single ☐ Married ☐ Divorced/ Separated ☐ Widowed ☐ Unknown

6. Residential District:

   Hong Kong and Islands

   ☐ Central and Western ☐ Eastern ☐ Southern ☐ Wanchai ☐ Islands/Tung Chung

   Kowloon

   ☐ Kwun Tong ☐ Wong Tai Sin ☐ Kowloon City ☐ Mongkok ☐ Shamshuipo
   ☐ Yaumatei ☐ Tseung Kwan O ☐ Sai Kung

   New Territories

   ☐ Kwai Chung ☐ Tsuen Wan ☐ Tsing Yi ☐ Tuen Mun ☐ Yuen Long
   ☐ Tin Shui Wai ☐ Shatin ☐ Ma On Shan ☐ Tai Po
   ☐ North (Sheung Shui and Fanling)

7. Type of Accommodation:

- ☐ Public Housing Estate
- ☐ Private Tenement
- ☐ Temporary Shelter
- ☐ Others (please specify): _____

8. Physical and Mental Condition:

8.1 Degree of Visual Impairment:

- ☐ Blindness
- ☐ Severe Vision Impairment

} Please attach the Visual Examination Form at Annex 1

Certified in _____ / _____
Month Year

8.2 Mobility:

- ☐ Walk independently
- ☐ Self-ambulatory with walking aid or wheelchair
- ☐ Walk with escort
- ☐ Chairbound / bedridden / paralysed

8.3 Mental State:

- ☐ Normal / alert
- ☐ Disturbing / apathetic
- ☐ Confused
- ☐ Others (please specify): _____

8.4 Incontinence:

- ☐ Nil
- ☐ Occasional urine or faecal soiling
- ☐ Frequent urine or faecal soiling

9. Welfare Assistance Currently Receiving:

- ☐ Disability Allowance
- ☐ Comprehensive Social Security Assistance
- ☐ Old Age Allowance
- ☐ Enhanced Home and Community Care Services / Integrated Home Care Service
- ☐ Community Nursing Service
- ☐ Day Care Centre Service

PART B Location Preference

(Three parallel choices of home / district / region can be specified below. Please tick "No" if applicant does not have special location preference.)

☐ No

☐ Yes: Location preferences - 1. _____

2. _____

3. _____

PART C Source of Referral

Referring Office: _____

Referring Agency: _____

Address: _____

_____

File Ref. No.: _____

Tel No.: _____ Fax No.: _____

The applicant has been informed that the information contained in this form will be used by the Social Welfare Department and the Hospital Authority for consideration of this application and related purposes.

PART D Declaration

☐ Referrer has declared that there is no conflict of interest in handling this application. Referrer is not a family member or personal friend of the applicant and has no personal or social ties with the applicant, and she/he has notified the applicant/family member(s)/guardian/carer(s) that SWD and the referring agency will not charge for the application and referral for service. The applicant/family member(s)/guardian/carer(s) should report to the Independent Commission Against Corruption (ICAC) immediately in case anyone offers to assist in application for placement in return for remuneration. Attempted bribery by any person is also an offence in law, SWD will refer the case to ICAC for investigation.

Signature: _____

Name of Referrer: _____

Date: _____

Supervisor's Endorsement

Signature: _____

Name of Supervisor: _____

Date: _____

Visual Examination Form
for Admission to Care and Attention Home for the Aged Blind

(to be completed by Medical Officer of Eye Hospital / Eye Clinic or Ophthalmologist)

Only person aged 60 or above and is certified as **blindness** or with **severe vision impairment** is eligible to apply for Care and Attention Home for the Aged Blind

Name of Applicant:_____ Sex:_____

HKID No.:_____(___) Date of Birth: _____

Hospital / Clinic Reference No.: _____

Level of vision impairment [Note]

	Right Eye	Left Eye
Visual Acuity (corrected)		
Visual Field		
Cause of Blindness		

Certification:

This is to certify that the above-named patient is suffering from **blindness / severe vision impairment / moderate vision impairment / mild vision impairment.

(** Please delete the inappropriate item.)

Note:

The classification of vision impairment as referenced with the World Health Organisation International Classification of Diseases 11th Revision (Version 05/2021):

Classification	**Presenting distance visual acuity**[#]	
	Worse than:	**Equal to or better than:**
Blindness	• 3/60	• No light perception
Severe vision impairment	• 6/60	• 3/60
	People with constricted vision field in which the widest field diameter subtends an angular subtense of 20 degrees or less, irrespective of visual acuity	
Moderate vision impairment	• 6/18	• 6/60
Mild vision impairment	• 6/12	• 6/18

[#] Visual acuity refers to the visual acuity of the better eye with correcting devices.

Signature:_____ Date: _____

Doctor's full name:_____ Chop of Hospital / Clinic:_____

(Updated March 2025)

RESTRICTED

Confirmation of Registration

From: Central Referral System for Rehabilitation Services
Subsystem for Elderly Persons with Visual Impairment (CRSRehab-VI)
Social Welfare Department
Room 901, 9/F Wu Chung House
213 Queen's Road East, Wanchai, Hong Kong

To:

CRSRehab-VI Tel.: Your Ref.:
Fax: Your Fax:
Date:

The following applicant has been registered in CRSRehab–VI for rehabilitation service. Please kindly verify the following data, raise amendment and update any change to CRSRehab–VI by *Form 3*. For case enquiries, please contact the staff-on-duty at 2892 5136. For data protection, only enquiries from the referrers will be answered.

I. Information of referrer
Tel No.

II. Personal Particulars
Name (English): Sex:
Name (Chinese): Date of Birth:
HKIC: Residential District:

III Disability
Degree of Visual Impairment: Mobility:
Mental State: Incontinence

IV. Placement Request
Type of placement:
CRSRehab-VI no. Application date:
Status of service:
Location preference:

V. Status of applicant Priority :

( )
Oi/c CRSRehab - VI

限閱文件
RESTRICTED

社會福利署
康復服務中央轉介系統
申請康復服務登記書
Notification of Registration for Rehabilitation Services
Central Referral System for Rehabilitation Services
Social Welfare Department

/ /

致： 康復服務申請人（經個案社工／轉介者轉交）
To: Applicant (Via Caseworker/Referrer)

下列申請經已於社會福利署（社署）康復服務中央轉介系統內登記，詳情如下：
The following application has been registered in the Central Referral System for Rehabilitation Services of the Social Welfare Department (SWD) with details listed as below:

姓名：
Name: _____
香港身份證：
Hong Kong Identity Card: _____
申請日期：
Date of Application: _____
申請輪候的康復服務：
Rehabilitation Service(s) Applying for: _____
輪候狀況：
Status on Waiting List: _____
檔案號碼：
Your Reference: _____
申請人編號：
CRSRehab No.: _____
服務地區選擇：
Location Preference: _____

倘若你獲得編配所申請的服務，康復服務中央轉介系統將會透過你的社工／轉介者與你聯絡，安排接受有關服務。為令各方面保持緊密聯絡，若果你的聯絡地址、電話或所需的服務已轉變，請儘快通知個案社工／轉介者，以便他／她將有關資料轉達本系統。就上述服務的申請及轉介事宜，社署及轉介機構不會收取任何費用。若有人藉詞協助申請而索取利益，申請人應立即向廉政公署舉報。任何人意圖行賄，亦屬違法，社署會將個案轉介廉政公署查究。

Once you are selected for a placement in rehabilitation unit, the Central Referral System for Rehabilitation Services will inform you via the referring social worker to prepare for acceptance of placement offer. For maintaining good contacts among all parties concerned, please inform the referring social worker as early as possible if you have changes in your address, telephone number or rehabilitation services required, so that information may be updated at the Central Referral System for Rehabilitation Services. SWD and the referring agency will not charge for the application and referral for service. The applicant should report to the Independent Commission Against Corruption (ICAC) immediately in case anyone offers to assist in application for placement in return for remuneration. Attempted bribery by any person is also an offence in law, SWD will refer the case to ICAC for investigation.

如你對以上的申請有任何查詢，請與你的社工／轉介者聯絡：
Should you have any enquiry on the above application, you may contact your referring social worker:

社工／轉介者姓名：
Caseworker / Referrer Name: _____
機構名稱：
Centre: _____
辦公室地址：
Office Address: _____
聯絡電話（內線）：
Phone Contact No. (ext.): _____

RESTRICTED

Central Referral System for Rehabilitation Services
Subsystem for Elderly Persons with Visual Impairment
Application for Transfer to Other Residential Care Unit for Persons with Disabilities Under Same Service Type

Only person aged 60 or above and is certified as **blindness** or with **severe vision impairment** is eligible to apply for Care and Attention Home for the Aged Blind.

Please use BLOCK LETTERS to fill in the information or give a '✓' in the boxes, whichever is required.

PART A Applicant's Personal Information

1. Name of Applicant: _____ (_____)
   (In English, Surname first) (In Chinese)

2. HKID No.: _____( ) *or*

   Certificate of Exemption : L/M ( ) in RP 3/3/220/( )

3. Date of Birth : _____/_____/_____
   Day Month Year

4. Sex: ☐ Male ☐ Female

5. Date of Admission : _____/_____/_____
   Day Month Year

6. Name of Residential Unit : _____

7. Mobility
   - ☐ Walk independently
   - ☐ Self-ambulatory with walking aid or wheelchair
   - ☐ Walk with escort
   - ☐ Chairbound / bedridden / paralysed

8. Mental State:
   - ☐ Normal / alert
   - ☐ Disturbing / apathetic
   - ☐ Confused
   - ☐ Others (please specify): _____

9. Incontinence:
   - ☐ Nil
   - ☐ Occasional urine or faecal soiling
   - ☐ Frequent urine or faecal soiling

10. Welfare Assistance Currently Receiving:
    - ☐ Disability Allowance
    - ☐ Comprehensive Social Security Assistance
    - ☐ Old Age Allowance

PART B **Reason(s) of Application for Transfer**

_____

_____

PART C **Location Preference**

(Three parallel choices of home / district / region can be specified below. Please tick "No" if applicant does not have special location preference.)

☐ No

☐ Yes: Location preferences - 1. _____

2. _____

3. _____

PART D **Source of Referral**

Referring Office: _____

Referring Agency: _____

Referrer: _____

Address: _____

File Ref. No.: _____

Tel No.: _____ Fax No.: _____

Signature: _____ Date: _____

☐ Referrer has declared that there is no conflict of interest in handling this application. Referrer is not a family member or personal friend of the applicant and has no personal or social ties with the applicant, and she/he has notified the applicant/family member(s)/guardian/carer(s) that SWD and the referring agency will not charge for the application and referral for service. The applicant/family member(s)/guardian/carer(s) should report to the Independent Commission Against Corruption (ICAC) immediately in case anyone offers to assist in application for placement in return for remuneration. Attempted bribery by any person is also an offence in law, SWD will refer the case to ICAC for investigation.

PART E **Endorsement***

Comment: _____

Name: _____ Signature: _____

Post Title: _____ Date: _____

*Endorsement should be obtained from agency head/designated representative of non-governmental organisation or DSWO/ADSWO of SWD.

RESTRICTED

Outcome of Application for Transfer to Other Residential Care Unit for Persons with Disabilities Under Same Service Type

From: Central Referral System for Rehabilitation Services
Subsystem for Elderly Persons with Visual Impairment (CRSRehab-VI)
Social Welfare Department
Room 901, 9/F Wu Chung House
213 Queen's Road East, Wanchai, Hong Kong

To:

CRSRehab Tel.:
Fax:
Date:

Your Ref.:
Your Tel:
Your Fax:

Name:

HKIC:

CRSRehab No.:

The application for transfer to other residential care unit under same service type of the above-named has been received.

☐ Applicant has been **put back to the active waiting list**. The application date of residential care service on _____ is retained.

☐ The application is considered not justified and hence not approved. Should there is any change in circumstances in future warranting application for transfer, applicant may make a fresh application again.

( )
Oi/c CRSRehab-VI

RESTRICTED (限閱文件)

入住盲人護理安老院申請表
Application Form for Admission to Care and Attention Home for the Aged Blind

第一部　申請表格〔由申請人簽署〕 Part I: Application Form (to be signed by applicant)

(甲)　獲編配盲人護理安老院名稱
(A)　Name of Care and Attention Home for the Aged Blind to be Allocated

_____

(乙)　申請人資料
(B)　Particulars of Applicant

申請人姓名　　性別:男/女
Name of Applicant: _____ (　　)　　Sex: M/F

地址
Address: _____

電話
_____　Tel. No.: _____

通訊地址（如與上址不同）
Correspondence Address
(if different from above address) _____

出生日期　　婚姻狀況
Date of Birth: _____　Marital Status: _____

身份証號碼　　所操方言
HKID No.: _____　Dialect Used: _____

(丙)　申請人同意書
(C)　Applicant's Written Consent

本人同意將所附資料，包括視力和社會背景紀錄，提供予有關機構，以便審核本人入住盲人護理安老院申請。

I consent to release the attached data, including visual and social, to the appropriate authority for consideration of my application for admission to Care and Attention Home for the Aged Blind.

申請人姓名
Name of Applicant : _____

簽署
Signature : _____

日期
Date : _____

Part II: Case Summary (to be completed by referring worker)

(A) Particulars of Family Members of Close Relatives

Name	Sex	Relationship with applicant	if not living with applicant, please provide Tel. No.

FOR EMERGENCY CONTACT

1. Name: _____ Relationship: _____ Tel. No.: _____
   Address: _____
2. Name: _____ Relationship: _____ Tel. No.: _____
   Address: _____

(B) Financial Status and Income (please "✓" appropriate items)

☐ On Comprehensive Social Security Assistance
☐ On Disability Allowance
☐ On Old Age Allowance
☐ Contribution from family members / relatives
☐ On Pension
☐ Others (please specify): _____

If in receipt of CSSA/SSA

Social Security Field Unit: _____

Tel. No. : _____

Case Ref. No. : _____

(C) Living Arrangement

☐ Living alone
☐ Living with family / Others
☐ Living in Residential Care Home for the Elderly *(Name):* _____
☐ Others (please specify): _____

(D) Daily Living Activities

	Fully Capable	Partially Dependent on Others	Totally Dependent on Others
Bathing	☐	☐	☐
Dressing	☐	☐	☐
Feeding	☐	☐	☐
Washing face / hands	☐	☐	☐
Toileting	☐	☐	☐

(E) Mobility

☐ Walk independently
☐ Walk satisfactorily with aids
☐ Walk poorly even with aids
☐ Chairbound / wheelchair bound
☐ Bed-bound / paralysed
☐ Frequently falls

(F) Brief Social History / Additional Remarks

(G) Source of Referral

Referring agency : _____

Referring office : _____

Address : _____

File Ref. No. : _____ Fax No. : _____

Referring Worker		Countersigning Officer	
Signature	: _____	Signature	: _____
Name	: _____	Name	: _____
Post	: _____	Post	: _____
Tel. No.	: _____	Tel. No.	: _____
Date	: _____	Date	: _____

RESTRICTED

Data Updating Form

From:	_____ *(Name of Referring Office)*	To:	Central Referral System for Rehabilitation Services Subsystem for Elderly Persons with Visual Impairment Social Welfare Department Room 901, 9/F Wu Chung House 213 Queen's Road East, Wanchai, Hong Kong
	_____ *(Name of Organisation)*		
Ref.:	_____		
Tel.:	_____	Your Ref.:	
Fax:	_____	Tel.:	2892 5136
Date:	_____	Fax:	2893 6983

Name of applicant: _____ HKIC No.: _____ CRSRehab No.: _____

Information to be updated: (✓ in the appropriate box)

☐ Placement is no longer required. (Case can be removed from CRSRehab-VI)

☐ Change in location preference: -

-

-

☐ Change in referring office #: *(New office name)* _____

☐ Change in referrer #: *(New referrer name)* _____

(Phone number) _____ *(Fax number)* _____

☐ Applicant is discharged/ready for discharged from hospital. Please put the case back on waiting list.

☐ Change in applicant's personal particulars (residential district, disability, etc.)

Please specify: _____

☐ Others, please specify: _____

Signature: _____

Name: _____

Post: _____

c.c. New referrer (Fax:_____)

RESTRICTED

Removal from Waiting List

From: Central Referral System for Rehabilitation Services
Subsystem for Elderly Persons with Visual Impairment (CRSRehab-VI)
Social Welfare Department
Room 901, 9/F Wu Chung House
213 Queen's Road East, Wanchai, Hong Kong

To:

CRSRehab Tel.:
Fax:
Date:

Your Ref.:
Your Tel:
Your Fax:

Name:

HKIC:

CRSRehab No.:

The above-named application has been removed from the waiting list due to the following reason:

☐ Case closed in CRSRehab-VI upon:

☐ Hospitalisation of applicant. Please refer to the *Manual of Procedures* for CRSRehab for further information.

☐ Applicant being rejected twice by different agencies in the same service. Please arrange for re-assessment in the applicant's genuine service need.

( )
Oi/c CRSRehab - VI

Report of Vacancies

From: _____
(Name of Rehabilitation Unit)

_____
(Name of Organisation)

Ref.: _____
Tel.: _____
Fax: _____
Date: _____

To: Central Referral System for Rehabilitation Services
Subsystem for Elderly Persons with Visual Impairment
Room 901, 9/F Wu Chung House
213 Queen's Road East
Wanchai, Hong Kong

Tel.: 2892 5136
Fax: 2893 6983

1. Number of vacancies as at _____ / _____ / _____ (*DD/MM/YYYY*)

Service	C&A/AB	
Sex	M	F
(a) Capacity		
(b) Enrolment		
(c) No. of referral(s) approved and pending admission		
(d) No. of referral(s) being processed		
(e) No. of immediate vacancy		
Remarks [(e) = (a) – (b) – (c) – (d)]		

2. Number of vacancies anticipated in forthcoming 2 months (excluding those reported in item 1):

Service	C&A/AB	
Sex	M	F
Vacancies		
Available date(s)		
Remarks		

Signature: _____

Name: _____

Post: _____

RESTRICTED

Selection for Placement

From: Central Referral System for Rehabilitation Services
Subsystem for Elderly Persons with Visual Impairment (CRSRehab-VI)
Social Welfare Department
Room 901, 9/F Wu Chung House
213 Queen's Road East, Wanchai, Hong Kong

To:

CRSRehab Tel.:	Your Ref.:
Fax:	Your Tel:
Date:	Your Fax:

The following applicant has been selected for placement in rehabilitation unit with details shown below. Please reply to CRSRehab by *Form 7* **within 21 day(s)**.

Your early reply will facilitate the applicant's admission for service. You may consider contacting the rehabilitation unit for arrangement of visits for the applicant or information on the service as appropriate. (For priority placement, please review and confirm the applicant still has urgent service need.)

Name of applicant:

HKIC:

CRSRehab No.:

Name of Rehabilitation Unit:

Type of Service:

Address:

Tel. No.:

Fax No.:

Date of Selection:

For applicant accepting the placement offer, please forward the following required papers:

1. CRSRehab-VI Form 7
2. CRSRehab VI Form 2
3. Annex 1 to CRSRehab-VI Form 1

( )
Oi/c CRSRehab - VI

RESTRICTED

Notification of Case Selection to Rehabilitation Unit

From: Central Referral System for Rehabilitation Services
Subsystem for Elderly Persons with Visual Impairment (CRSRehab-VI)
Social Welfare Department
Room 901, 9/F Wu Chung House
213 Queen's Road East, Wanchai, Hong Kong

To:

CRSRehab Tel.: Your Tel:
Fax: Your Fax:
Date:

Listed below for your information are the application(s) that have been selected from the waiting list for placement in your service unit. These applicants have 21 day(s)' time to decide whether they accept the placement offer or not. Subject to their acceptance of placement offer, the referrer and/or CRSRehab will send relevant documents to you for case intake once they are available.

While the applicants are considering acceptance of placement offer, they and/or their family members may, through the referring officers, approach your unit for visits or information on services provided.

Since some of the applicants may eventually decline the placement offer, if you need updated referral situation of the list, please contact the undersigned officer of the CRSRehab.

Name	Sex/ Age	CRSRehab No.	Referring Office	Name of Referrer	Tel	Normal/ Priority

Please be reminded that your staff should have declared that there is no conflict of interest in handling the application(s). They are not a family member or personal friend of the applicant and have no personal or social ties with the applicant.

( )
Oi/c CRSRehab - VI

RESTRICTED

Reply to CRSRehab-VI on Selection for Placement

From: _____ *(Name of Referring Office)*	To: Central Referral System for Rehabilitation Services Subsystem for Elderly Persons with Visual Impairment (CRSRehab-VI) Social Welfare Department Room 901, 9/F Wu Chung House 213 Queen's Road East, Wanchai, Hong Kong
_____ *(Name of Organisation)*	
Ref: _____	
Tel: _____	Tel: 2892 5136
Fax: _____	Fax: 2893 6983
Date: _____	

Application for placement to: _____
(name of rehabilitation unit)

Name: _____ HKIC No.: _____ CRSRehab No.: A _____

☐ **Applicant accepts the offer.** (✓ in the appropriate box)
(For priority placement, the applicant is confirmed to have urgent service need.)

The following documents are attached:
- ☐ CRSRehab-VI Form 2
- ☐ Annex 1 to CRSRehab-VI Form 1
- ☐ Others, please specify: _____

☐ **Applicant declines the offer.** (Please ✓ only one box):
- ☐ Applicant considers the location of rehabilitation unfavourable
- ☐ Prefer to live with/be looked after by family member(s)
- ☐ No immediate need for service.
- ☐ Ill health / unstable mental or emotional condition
- ☐ Applicant left Hong Kong or emigrated overseas
- ☐ Lost contact with applicant
- ☐ Applicant passed away
- ☐ Ability improved, upward movement required
- ☐ Ability deteriorated, downward movement required
- ☐ Others, please specify: _____

☐ **Applicant is temporarily hospitalized.**
Name of Hospital: _____
Admission date: _____
Diagnosis/Treatment required: _____

Signature: _____
Name: _____
Post: _____

c.c. Rehabilitation Unit ( ) Fax: ( )

RESTRICTED

Reminder to Referrer

From: Central Referral System for Rehabilitation Services
Subsystem for Elderly Persons with Visual Impairment (CRSRehab-VI)
Social Welfare Department
Room 901, 9/F Wu Chung House
213 Queen's Road East, Wanchai, Hong Kong

To:

CRSRehab Tel.:	Your Ref.:
Fax:	Your Tel:
Date:	Your Fax:

Name of applicant:

HKIC:

CRSRehab No.:

Name of Rehabilitation Unit/Project Team:

Date of Selection:

CRSRehab has not received your reply to the placement offer for the above-named applicant. I would be grateful if you would reply to CRSRehab via *Form 7* **within 2 week(s)**. Otherwise, the applicant would be removed from the waiting list.

If you have already replied to this, I would much appreciate if you would forward a copy of *Form 7* to CRSRehab.

( )
Oi/c CRSRehab - VI

c.c. Agency Head

RESTRICTED

Referral for Admission

From: Central Referral System for Rehabilitation Services
Subsystem for Elderly Persons with Visual Impairment (CRSRehab-VI)
Social Welfare Department
Room 901, 9/F Wu Chung House
213 Queen's Road East, Wanchai, Hong Kong

To:

CRSRehab Tel.: Your Tel:
Fax: Your Fax:
Date:

Referral for Admission to

_____

I forward the referral papers listed below of the following applicant for admission to your centre. Please kindly reply by completing the *Report on Case Intake/Discharge (Form 9)* within 28 day(s).

By copy of this, the referrer is requested to contact the rehabilitation unit for case intake.

Case particulars:

Name of applicant: Hong Kong Identity Card:
Sex / D.O.B.: CRSRehab No.:

Referral papers attached:

1. CRSRehab-VI Form 2
2. Annex 1 to CRSRehab-VI Form 1

( )
Oi/c CRSRehab - VI

c.c. Referring office (without enclosure):
Service Centre, (Fax no.:)
(case ref.)

RESTRICTED

Report to CRSRehab-VI on Case Intake/Discharge

From:	_____ *(Name of Rehabilitation Unit)*	To:	Central Referral System for Rehabilitation Services Subsystem for Elderly Persons with Visual Impairment (CRSRehab-VI) Social Welfare Department Room 901, 9/F Wu Chung House 213 Queen's Road East, Wanchai, Hong Kong
	_____ *(Name of Organisation)*		
Ref:	_____		
Tel:	_____		
Fax:	_____	Tel:	2892 5136
Date:	_____	Fax:	2893 6983

Name: _____ HKIC No.: _____ CRSRehab No.: _____

Please be informed the above-named case has been:

☐ **admitted** into service from _____ *(date).*

☐ **rejected** upon case screening due to:

☐ unstable mental/emotional condition ☐ acute health problem

☐ no vacancy ☐ severe behavioral problem (please specify):

☐ health condition does not meet the admission criteria

☐ others (please specify): _____

☐ **self-withdrawn** by applicant upon case screening due to:

☐ no immediate need for service ☐ prefer to live with/cared by family members

☐ unfavourable location ☐ lost trace

☐ applicant/family members do not disclose any reason

☐ others (please specify): _____

☐ **temporarily hospitalized**:

Name of Hospital: _____

Admission date: _____

Diagnosis/Treatment required: _____

☐ **discharged** from our service on _____ *(date)* due to:

☐ formally discharge (please specify reason) _____

☐ internally transfer (please specify the rehabilitation unit) _____

Signature: _____

Name: _____

Post: _____

c.c. Referring office: (case ref.)

Reminder to Rehabilitation Unit

From: Central Referral System for Rehabilitation Services
Subsystem for Elderly Persons with Visual Impairment (CRSRehab-VI)
Social Welfare Department
Room 901, 9/F Wu Chung House
213 Queen's Road East, Wanchai, Hong Kong

To:

CRSRehab Tel.: Your Tel:
Fax: Your Fax:
Date:

The following application(s) has/ have been referred to your unit for consideration of admission for more than 28 day(s). So far, no reply has been received by CRSRehab. I would be grateful for your prompt decision on this/ these application(s) and reply to CRSRehab via *Form 9* with a copy to the referrer concerned **within 2 week(s)**.

Date of Referral	CRSRehab No.	Name of Applicant	Sex	Age

( )
Oi/c CRSRehab - VI

c.c. Agency Head
Referrer: [ ]

RESTRICTED

Application for Priority Placement

From: _____ *(Name of Referring Office)*	To: Central Referral System for Rehabilitation Services Subsystem for Elderly Persons with Visual Impairment (CRSRehab-VI)
_____ *(Name of Organisation)*	Social Welfare Department
Ref: _____	Room 901, 9/F Wu Chung House
Tel: _____	213 Queen's Road East, Wanchai, Hong Kong
Fax: _____	Tel: 2892 5136
Date: _____	Fax: 2893 6983

1. Case Particulars

Name: _____ Sex/D.O.B.: ____/____ HKIC No.: _____

Address: _____ Tel.: _____

Disability: _____

Placement Required: C&A/AB CRSRehab No.: A

2. Particulars of family members and relatives

Name	Relationship	Sex/Age	Occupation/ Schooling	Income/ school fee	Disability/ill health (if any)	Remarks
		/				
		/				
		/				
		/				

3. Case/family background

_____

_____

_____

_____

_____

4. Reasons for priority placement

_____

_____

_____

_____

_____

Prepared by: _____ Endorsed by* _____

Signature: _____ Signature: _____

Name: _____ Name: _____

Post: _____ Post: _____

* Endorsement should be obtained from agency head/designated representative of non-governmental organisation or DSWO/ADSWO of SWD.

RESTRICTED

Outcome of Application for Priority Placement

From: Central Referral System for Rehabilitation Services
Subsystem for Elderly Persons with Visual Impairment (CRSRehab-VI)
Social Welfare Department
Room 901, 9/F Wu Chung House, 213 Queen's Road East
Wanchai, Hong Kong

To:

CRSRehab Tel.: Your Ref.:
Fax: Your Tel:
Date: Your Fax:

Name of applicant:

HKIC:

CRSRehab No.:

☐ I am pleased to inform you that your application for priority placement for the above-named applicant is approved. The particulars of the placement are detailed below:

Type of Placement:

Date of Priority Assigned:

Location preference:

☐ The captioned application for priority placement is not approved or not necessary due to the following reason:

If you have any question, please contact the undersigned for discussion on the case.

( )
Oi/c CRSRehab - VI

Forms of the Subsystem for Small Group Home for Children with Mild Intellectual Disabilities (CRSRehab-SGHCMID)

RESTRICTED

Central Referral System for Rehabilitation Services
Subsystem for Small Group Home for Children with Mild Intellectual Disabilities
(CRSRehab–SGHCMID)
Registration Form

I. Personal Particulars

1. Name: _____ *(English)* _____ *(Chinese)*
2. Sex: ☐ Male ☐ Female
3. Date of Birth: _____*(dd)* _____*(mm)* _____*(yyyy)*
4. HKBC/IC No.: _____
5. Residential District:

Hong Kong and Islands
☐ Central and Western ☐ Eastern ☐ Southern ☐ Wanchai
☐ Islands

Kowloon
☐ Kwun Tong ☐ Wong Tai Sin ☐ Kowloon City ☐ Mongkok
☐ Shamshuipo ☐ Yaumatei ☐ Tseung Kwan O ☐ Sai Kung

New Territories
☐ Kwai Tsing ☐ Tsuen Wan ☐ Tuen Mun ☐ Yuen Long
☐ Tin Shui Wai ☐ Tai Po ☐ Shatin ☐ Ma On Shan
☐ North (Sheung Shui and Fanling)

II. Disability

1. Physical Disability ☐ A: With Physical Disability, please specify: _____
   ☐ N: No Physical Disability
2. Spastic / Cerebral palsy ☐ A: Spastic ☐ B: Cerebral palsy ☐ N: Not spastic or cerebral palsy
3. Hearing Impairment ☐ A: Deaf ☐ B: Partially Impaired ☐ N: Normal
4. Vision Impairment ☐ A: Blind ☐ B: Partially Impaired ☐ N: Normal
5. Intellectual Disability ☐ Mild Intellectual Disability
   Date of psychological assessment: _____*(dd)* _____*(mm)* _____*(yyyy)*
   (please attached psychological report)
6. Psychiatric Diagnosis ☐ A: With psychiatric diagnosis: (please specify) _____
   ☐ N: No reported psychiatric diagnosis
7. Speech Impairment ☐ Y: Yes ☐ N: Normal
8. Autism Spectrum Disorder ☐ Y: Yes ☐ N: Normal
9. Other Illness / Disability _____

10. Mobility ☐ A: Walk unaided ☐ B: Walk with escort ☐ C: Walk with rehabaid ☐ D: Wheelchair bound ☐ E: Bed ridden

11. Ability to Climb Stairs / Slope ☐ A: Capable to climb stairs / slope by self ☐ B: Climb stairs / slope with other's assistance ☐ C: Unable to climb stairs / slope even with other's assistance

12. Public Transport (Excluding taxi) ☐ A: Manage without escort ☐ B: Manage with escort ☐ C: Cannot manage with escort

13. Treatment Required ☐ A: Occupational therapy ☐ B: Physiotherapy ☐ C: Others: _____

14. Assistive Devices Used ☐ A: Wheelchair ☐ B: Ambulator ☐ C: Prosthesis / artificial legs ☐ D: Calipers ☐ E: Special boots ☐ F: Hearing aid ☐ G: Crutches ☐ H: Tripod ☐ I: Others: _____

III. Placement Arrangement

1. Service Recommended

☐ Small group home for mildly mentally handicapped children (SGHMMHC)

☐ Integrated Small group home for mildly mentally handicapped children (ISGH)

☐ SGHMMHC + ISGH

2. Location

☐ No (**Waiting time will be much shorter**)

☐ Yes (Please indicate **5 choices** in region / district / service unit)

Description

1. _____
2. _____
3. _____
4. _____
5. _____

IV. Declaration

☐ Referrer has declared that there is no conflict of interest in handling this application. Referrer is not a family member or personal friend of the applicant and has no personal or social ties with the applicant, and she/he has notified the applicant/family member(s)/guardian/carer(s) that SWD and the referring agency will not charge for the application and referral for service. The applicant/family member(s)/guardian/carer(s) should report to the Independent Commission Against Corruption (ICAC) immediately in case anyone offers to assist in application for placement in return for remuneration. Attempted bribery by any person is also an offence in law, SWD will refer the case to ICAC for investigation.

Case ref. no.: _____ Tel.: _____

Name of referrer: _____ Fax.: _____

Office / Centre: _____ Date: _____

RESTRICTED

Confirmation of Registration

From: Central Referral System for Rehabilitation Services
Subsystem for Small Group Home for Children with Mild Intellectual Disabilities
(CRSRehab-SGHCMID)
Social Welfare Department
Room 901, 9/F Wu Chung House, 213 Queen's Road East
Wanchai, Hong Kong

To:

CRSRehab-SGHCMID Tel.: Your Ref.:
Fax: Your Fax:
Date:

The following applicant has been registered in CRSRehab–SGHCMID for rehabilitation service. Please kindly verify the following data, raise amendment and update any subsequent change to CRSRehab–SGHCMID by *Form 3*. For case enquiries, please contact the staff-on-duty at 2892 5136 . For data protection, only enquiries from the referrer will be answered.

I. Information of referrer
Tel No.

II. Personal Particulars
Name (English): Sex:
Name (Chinese): Date of Birth:
HKBC: Residential District:

III. Disability
Physical disability: Spastic/cerebral palsy:
Hearing: Vision:
IQ score: Date of assessment:
Mental Illness: Speech:
Autism:
Other disability: Mobility:
Climb stairs/slope: Public transport:
Treatment required: Rehabaid used:

IV. Placement Request
Type of placement:
CRSRehab-SGHMIDC no. Application date:
Status of service:
Location preference: 1.
2.
3.
4.
5.

V. Status of applicant Priority :

( )
Oi/c CRSRehab - SGHCMID

限閱文件
RESTRICTED

社會福利署
康復服務中央轉介系統
申請康復服務登記書
Notification of Registration for Rehabilitation Services
Central Referral System for Rehabilitation Services
Social Welfare Department

/ /

致： 康復服務申請人（經個案社工／轉介者轉交）
To: Applicant (Via Caseworker/Referrer)

下列申請經已於社會福利署（社署）康復服務中央轉介系統內登記，詳情如下：
The following application has been registered in the Central Referral System for Rehabilitation Services of the Social Welfare Department (SWD) with details listed as below:

姓名：
Name: _____
香港出生證明書：
Hong Kong Birth Certificate: _____
申請日期：
Date of Application: _____
申請輪候的康復服務：
Rehabilitation Service(s) Applying for: _____
輪候狀況：
Status on Waiting List: _____
檔案號碼：
Your Reference: _____
申請人編號：
CRSRehab No.: _____
服務地區選擇：
Location Preference: _____

倘若你獲得編配所申請的服務，康復服務中央轉介系統將會透過你的社工／轉介者與你聯絡，安排接受有關服務。為令各方面保持緊密聯絡，若果你的聯絡地址、電話或所需的服務已轉變，請儘快通知個案社工／轉介者，以便他／她將有關資料轉達本系統。就上述服務的申請及轉介事宜，社署及轉介機構不會收取任何費用。若有人藉詞協助申請而索取利益，申請人應立即向廉政公署舉報。任何人意圖行賄，亦屬違法，社署會將個案轉介廉政公署查究。

Once you are selected for a placement in rehabilitation unit, the Central Referral System for Rehabilitation Services will inform you via the referring social worker to prepare for acceptance of placement offer. For maintaining good contacts among all parties concerned, please inform the referring social worker as early as possible if you have changes in your address, telephone number or rehabilitation services required, so that information may be updated at the Central Referral System for Rehabilitation Services. SWD and the referring agency will not charge for the application and referral for service. The applicant should report to the Independent Commission Against Corruption (ICAC) immediately in case anyone offers to assist in application for placement in return for remuneration. Attempted bribery by any person is also an offence in law, SWD will refer the case to ICAC for investigation.

如你對以上的申請有任何查詢，請與你的社工／轉介者聯絡：
Should you have any enquiry on the above application, you may contact your referring social worker:

社工／轉介者姓名：
Caseworker / Referrer Name: _____
機構名稱：
Centre: _____
辦公室地址：
Office Address: _____
聯絡電話（內線）：
Phone Contact No. (ext.): _____

RESTRICTED

Central Referral System for Rehabilitation Services
Subsystem for Small Group Home for Children with Mild Intellectual Disabilities
Application for Transfer to Other Residential Care Unit for Persons with Disabilities Under Same Service Type

I. Personal Particulars

1. Name: _____ _____
(English) *(Chinese)*

2. Sex: ☐ Male ☐ Female

3. Date of Birth: ___*(dd)* _____*(mm)* _____*(yyyy)*

4. HKBC/IC No.:

5. Date of Admission : ___*(dd)*_____*(mm)*_____*(yyyy)*

6. Name of Residential Unit : _____

II. Disability

1. Physical Disability ☐ A: With Physical Disability, please specify: _____
☐ N: No Physical Disability

2. Spastic / Cerebral palsy ☐ A: Spastic ☐ B: Cerebral palsy ☐ N: Not spastic or cerebral palsy

3. Hearing Impairment ☐ A: Deaf ☐ B: Partially Impaired ☐ N: Normal

4. Vision Impairment ☐ A: Blind ☐ B: Partially Impaired ☐ N: Normal

5. Intellectual Disability ☐ Mild Intellectual Disability
Date of psychological assessment: _____ *(dd)* _____ *(mm)* _____ *(yyyy)*
(please attached psychological report)

6. Psychiatric Diagnosis ☐ A: With psychiatric diagnosis: (please specify) _____
☐ N: No reported psychiatric diagnosis

7. Speech Impairment ☐ Y: Yes ☐ N: Normal

8. Autism Spectrum Disorder ☐ Y: Yes ☐ N: Normal

9. Other Illness / Disability _____

10. Mobility ☐ A: Walk unaided ☐ B: Walk with escort ☐ C: Walk with rehabaid
☐ D: Wheelchair bound ☐ E: Bed ridden

11. Ability to Climb Stairs / Slope ☐ A: Capable to climb stairs / slope by self
☐ B: Climb stairs / slope with other's assistance
☐ C: Unable to climb stairs / slope even with other's assistance

12. Public Transport (Excluding taxi) ☐ A: Manage without escort ☐ B: Manage with escort
☐ C: Cannot manage with escort

13. Treatment Required ☐ A: Occupational therapy ☐ B: Physiotherapy
☐ C: Others: _____

14. Assistive Devices Used ☐ A: Wheelchair ☐ B: Ambulator ☐ C: Prosthesis / artificial legs
☐ D: Calipers ☐ E: Special boots ☐ F: Hearing aid
☐ G: Crutches ☐ H: Tripod ☐ I: Others: _____

III. Reason(s) of Application for Transfer

_____

_____

IV. Placement Arrangement

1. Service Recommended
   - ☐ Small group home for mildly mentally handicapped children (SGHMMHC)
   - ☐ Integrated Small group home for mildly mentally handicapped children (ISGH)
   - ☐ SGHMMHC + ISGH
2. Location
   - ☐ No (**Waiting time will be much shorter**)
   - ☐ Yes (**Please** indicate **5 choices** in region / district / service unit)

   Description
   1. _____
   2. _____
   3. _____
   4. _____
   5. _____

V. Declaration

☐ Referrer has declared that there is no conflict of interest in handling this application. Referrer is not a family member or personal friend of the applicant and has no personal or social ties with the applicant, and she/he has notified the applicant/family member(s)/guardian/carer(s) that SWD and the referring agency will not charge for the application and referral for service. The applicant/family member(s)/guardian/carer(s) should report to the Independent Commission Against Corruption (ICAC) immediately in case anyone offers to assist in application for placement in return for remuneration. Attempted bribery by any person is also an offence in law, SWD will refer the case to ICAC for investigation.

Case ref. no.: _____ Tel.: _____
Name of referrer: _____ Fax.: _____
Office / Centre: _____ Date: _____

VI. Endorsement*

Comments: _____
Name: _____ Signature: _____
Post Title: _____ Date: _____

* Endorsement should be obtained from agency head/designated representative of non-governmental organisation or DSWO/ADSWO of SWD.

RESTRICTED

Outcome of Application for Transfer to Other Residential Care Unit for Persons with Disabilities Under Same Service Type

From: Central Referral System for Rehabilitation Services
Subsystem for Small Group Home for Children with Mild Intellectual Disabilities
(CRSRehab-SGHCMID)
Social Welfare Department
Room 901, 9/F Wu Chung House, 213 Queen's Road East
Wanchai, Hong Kong

To:

CRSRehab Tel.:
Fax:
Date:

Your Ref.:
Your Tel:
Your Fax:

Name:

HKIC:

CRSRehab No.:

The application for transfer to other residential care unit under same service type of the above-named has been received.

☐ Applicant has been **put back to the active waiting list**. The application date of residential care service on _____ is retained.

☐ The application is considered not justified and hence not approved. Should there is any change in circumstances in future warranting application for transfer, applicant may make a fresh application again.

( )
Oi/c CRSRehab-SGHCMID

RESTRICTED

Data Updating Form

From:	_____ *(Name of Referring Office)*	To:	Central Referral System for Rehabilitation Services Subsystem for Small Group Home for Children with Mild Intellectual Disabilities Social Welfare Department Room 901, 9/F Wu Chung House 213 Queen's Road East, Wanchai, Hong Kong
	_____ *(Name of Organisation)*		
Ref.:	_____		
Tel.:	_____	Your Ref.:	
Fax:	_____	Tel.:	2892 5136
Date:	_____	Fax:	2893 6983

Name of applicant: _____ HKIC No.: _____ CRSRehab No.: _____

Information to be updated: (please ✓ in the appropriate box)

☐ Placement is no longer required. (Case can be removed from CRSRehab-SGHCMID)

☐ Change in placement request: ☐ SGHMMHC only ☐ ISGH only
☐ SGHMMHC/ISGH

☐ Change in location preference: - _____
- _____
- _____
- _____
- _____

☐ Change in referring office #: *(New office name)* _____

☐ Change in referrer #: *(New office name)* _____
(Phone number) _____ *(Fax number)*

☐ Applicant is discharged/ready for discharged from hospital. Please put the case back on waiting list.

☐ Change in applicant's personal particulars (residential district, disability, etc.)
Please specify: _____

☐ Others, please specify: _____

Signature: _____
Name: _____
Post: _____

c.c. New referrer (Fax:_____

RESTRICTED

Removal from Waiting List

From: Central Referral System for Rehabilitation Services
Subsystem for Small Group Home for Children with Mild Intellectual Disabilities
(CRSRehab-SGHCMID)
Social Welfare Department
Room 901, 9/F Wu Chung House, 213 Queen's Road East
Wanchai, Hong Kong

To:

CRSRehab Tel.: Your Ref.:
Fax: Your Tel:
Date: Your Fax:

Name:

HKBC:

CRSRehab No.:

The above-named application has been removed from the waiting list due to the following reason:

☐ Case closed in CRSRehab-SGHCMID upon:

☐ Hospitalisation of applicant. Please refer to the *Manual of Procedures* for CRSRehab for further information.

☐ Applicant being rejected twice by different agencies in the same service. Please arrange for re-assessment in the applicant's genuine service need.

( )
Oi/c CRSRehab - SGHCMID

Report of Vacancies

From:	_____ *(Name of Rehabilitation Unit)*	To:	Central Referral System for Rehabilitation Services Subsystem for Small Group Home for Children with Mild Intellectual Disabilities Social Welfare Department 9/F Wu Chung House 213 Queen's Road East, Wanchai, Hong Kong
	_____ *(Name of Organisation)*		
Ref.:	_____		
Tel.:	_____		
Fax:	_____	Tel.:	2892 5136
Date:	_____	Fax:	2893 6983

1. Number of vacancies as at _____ / _____ / _____ (*DD/MM/YYYY*)

Service	SGHMMHC/ISGH	
Sex	M	F
(a) Capacity		
(b) Enrolment		
(c) No. of referral(s) approved and pending admission		
(d) No. of referral(s) being processed		
(e) No. of immediate vacancy		
Remarks [(e) = (a) – (b) – (c) – (d)]		

2. Number of vacancies anticipated in forthcoming 2 months (excluding those reported in item 1):

Service	SGHMMHC/ISGH	
Gender	M	F
Vacancies		
Available date(s)		
Remarks		

Signature: _____

Name: _____

Post: _____

RESTRICTED

Selection for Placement

From: Central Referral System for Rehabilitation Services
Subsystem for Small Group Home for Children with Mild Intellectual Disabilities
(CRSRehab-SGHCMID)
Social Welfare Department
Room 901, 9/F Wu Chung House, 213 Queen's Road East
Wanchai, Hong Kong

To:

CRSRehab Tel.:	Your Ref.:
Fax:	Your Tel:
Date:	Your Fax:

The following applicant has been selected for placement in rehabilitation unit with details shown below. Please reply to CRSRehab by *Form 7* **within 3 week(s)**.

Please note that the number of selected cases maybe slightly excess of the number of vacancies taking into account of possible decline cases. Your early reply will facilitate the applicant's admission for service. You may consider to contact the rehabilitation unit for arrangement of visits for the applicant or information on the service as appropriate.

Name of applicant:

HKBC:

CRSRehab No.:

Name of Rehabilitation Unit:

Type of Service:

Address:

Tel. No.:

Fax No.:

Date of Selection:

For applicant accepting the placement offer, please forward the following required papers:

1. CRSRehab-SGHCMID Form 7
2. Psychological report (for Intellectual Disabilities)
3. Referral Form for Placement in Residential Child Care Services (CRSRC 3)

( )
Oi/c CRSRehab - SGHCMID

RESTRICTED

Notification of Case Selection to Rehabilitation Unit

From: Central Referral System for Rehabilitation Services
Subsystem for Small Group Home for Children with Mild Intellectual Disabilities
(CRSRehab-SGHCMID)
Social Welfare Department
Room 901, 9/F Wu Chung House, 213 Queen's Road East
Wanchai, Hong Kong

To:

CRSRehab Tel.: Your Tel:
Fax: Your Fax:
Date:

Listed below for your information are the application(s) that have been selected from the waiting list for placement in your service unit. These applicants have 3 week(s)' time to decide whether they accept the placement offer or not. Subject to their acceptance of placement offer, the referrer and/or CRSRehab will send relevant documents to you for case intake once they are available.

While the applicants are considering acceptance of placement offer, they and/or their family members may, through the referring officers, approach your unit for visits or information on services provided.

Since some of the applicants may eventually decline the placement offer, if you need updated referral situation of the list, please contact the undersigned officer of the CRSRehab.

Name	Sex/ Age	CRSRehab No.	Referring Office	Name of Referrer	Tel	Normal/ Priority

Please be reminded that your staff should have declared that there is no conflict of interest in handling the application(s). They are not a family member or personal friend of the applicant and have no personal or social ties with the applicant.

( )
Oi/c CRSRehab - SGHCMID

RESTRICTED

Reply to CRSRehab-SGHCMID on Selection for Placement

From:	_____ *(Name of Referring Office)*	To:	Central Referral System for Rehabilitation Services Subsystem for Small Group Home for Children with Mild Intellectual Disabilities Social Welfare Department 9/F Wu Chung House 213 Queen's Road East, Wanchai, Hong Kong
	_____ *(Name of Organisation)*		
Ref:	_____		
Tel:	_____	Tel:	2892 5136
Fax:	_____	Fax:	2893 6983
Date:	_____		

Application for placement to: _____
(name of rehabilitation unit)

Name: _____ HKBC No.: _____ CRSRehab No.: M99

☐ **Applicant accepts the offer.** (Please ✓ in the appropriate box)
(For priority placement, the applicant is confirmed to have urgent service need.)

The following documents are attached:
- ☐ Referral Form for Placement in Residential Child Care Services (CRSRC 3)
- ☐ Psychological report
- ☐ Others, please specify: _____

☐ **Applicant declines the offer.** (Please ✓ only one box):
- ☐ Applicant considers the location of rehabilitation unfavourable
- ☐ Prefer to live with/be looked after by family member(s)
- ☐ No immediate need for service
- ☐ Transport not available/cannot be arranged
- ☐ Applicant left Hong Kong or emigrated overseas
- ☐ Lost contact with applicant
- ☐ Applicant passed away
- ☐ The placement offer does not match applicant's service request or location preference
- ☐ Ability improved, upward movement required
- ☐ Ability deteriorated, downward movement required
- ☐ Others, please specify: _____

☐ **Applicant is temporarily hospitalized.**

Name of Hospital: _____
Admission date: _____
Diagnosis/Treatment required: _____

Signature: _____
Name: _____
Post: _____

c.c. Rehabilitation Unit ( ) Fax: ( )

RESTRICTED

Second Reminder to Referrer

From: Central Referral System for Rehabilitation Services
Subsystem for Small Group Home for Children with Mild Intellectual Disabilities
(CRSRehab-SGHCMID)
Social Welfare Department
Room 901, 9/F Wu Chung House, 213 Queen's Road East
Wanchai, Hong Kong

To:

CRSRehab Tel.: Your Ref.:
Fax: Your Tel:
Date: Your Fax:

Name of applicant:

HKBC:

CRSRehab No.:

Name of Rehabilitation Unit:

Date of Selection:

CRSRehab has not received your reply to the placement offer for the above-named applicant. I would be grateful if you would reply to CRSRehab via *Form 7* **within 2 week(s)**. Otherwise, the applicant would be removed from the waiting list.

If you have already replied to this, I would much appreciate if you would forward a copy of *Form 7* to CRSRehab.

( )
Oi/c CRSRehab - SGHCMID

c.c.

RESTRICTED

Referral for Admission

From: Central Referral System for Rehabilitation Services
Subsystem for Small Group Home for Children with Mild Intellectual Disabilities (CRSRehab-SGHCMID)
Social Welfare Department
Room 901, 9/F Wu Chung House, 213 Queen's Road East
Wanchai, Hong Kong

To:

CRSRehab Tel.: Your Tel:
Fax: Your Fax:
Date:

Referral for Admission to

_____

I forward the referral papers listed below of the following applicant for admission to your centre. Please kindly reply by completing the *Report on Case Intake/Discharge (Form 9)* within 28 day(s).

By copy of this, the referrer is requested to contact the rehabilitation unit for case intake.

Case particulars:

Name of applicant: Hong Kong Birth Certificate:
Sex / D.O.B.: CRSRehab No.:

Referral papers attached:

1. Psychological report (for Intellectual Disabilities)
2. Referral Form for Placement in Residential Child Care Services (CRSRC 3)

( )
Oi/c CRSRehab - SGHCMID

c.c. Referring office (without enclosure):

RESTRICTED

Report to CRSRehab-SGHCMID on Case Intake/Discharge

From:	_____ *(Name of Rehabilitation Unit)*	To:	Central Referral System for Rehabilitation Services
	_____ *(Name of Organisation)*		Subsystem for Small Group Home for Children with Mild Intellectual Disabilities
Ref:	_____		Social Welfare Department
Tel:	_____		9/F Wu Chung House
Fax:	_____		213 Queen's Road East, Wanchai, Hong Kong
Date:	_____	Tel:	2892 5136
		Fax:	2893 6983

Name: _____ HKBC No.: _____ CRSRehab No.: _____

Please be informed the above-named case has been:

☐ **admitted** into service on _____ *(date).*

☐ **rejected** upon case screening due to:

- ☐ unstable mental/emotional condition
- ☐ acute health problem
- ☐ no vacancy
- ☐ severe behavioral problem (please specify):
- ☐ health condition does not meet the admission criteria
- ☐ others (please specify): _____

☐ **self-withdrawn** by applicant upon case screening due to:

- ☐ no immediate need for service
- ☐ prefer to live with/cared by family members
- ☐ unfavourable location
- ☐ lost trace
- ☐ applicant/family members do not disclose any reason
- ☐ others (please specify): _____

☐ **temporarily hospitalized**:

Name of Hospital: _____

Admission date: _____

Diagnosis/Treatment required: _____

☐ **discharged** from our service on _____ *(date)* due to:

_____

_____

Signature: _____

Name: _____

Post: _____

c.c. Referring office: (case ref.)

Reminder to Rehabilitation Unit

From: Central Referral System for Rehabilitation Services
Subsystem for Small Group Home for Children with Mild Intellectual Disabilities
(CRSRehab-SGHCMID)
Social Welfare Department
Room 901, 9/F Wu Chung House, 213 Queen's Road East
Wanchai, Hong Kong

To:

CRSRehab Tel.: Your Tel:
Fax: Your Fax:
Date:

The following application(s) has/ have been referred to your unit for consideration of admission for more than 4 week(s). So far, no reply has been received by CRSRehab. I would be grateful for your prompt decision on this/ these application(s) and reply to CRSRehab via *Form 9* with a copy to the referrer concerned **within 2 week(s)**.

Date of Referral	CRSRehab No.	Name of Applicant	Sex	Age

( )
Oi/c CRSRehab - SGHCMID

c.c. Agency Head
Referrer:

RESTRICTED

Application for Priority Placement

From:	_____ *(Name of Referring Office)*	To:	Central Referral System for Rehabilitation Services
	_____ *(Name of Organisation)*		Subsystem for Small Group Home for Children with Mild Intellectual Disabilities
Ref:	_____		Social Welfare Department
Tel:	_____		9/F Wu Chung House
Fax:	_____		213 Queen's Road East, Wanchai, Hong Kong
Date:	_____	Tel:	2892 5136
		Fax:	2893 6983

1. Case Particulars

Name: _____ Sex/D.O.B.: _____ HKBC No.: _____

Residential address: _____

Placement required: ☐ SGHMMHC only ☐ ISGH only ☐ SGHMMHC/ISGH CRSRehab No.: M99

2. Family Particulars

Name	Relationship	Gender/Age	Occupation/ Schooling	Income/ School fee	Disability/ Illness (if any)	Living with Applicant (✓ or X)

3. Case/Family background

_____

_____

_____

_____

_____

4. Description of applicant's disabilities, assessment and treatment given, and recommendation made by relevant professional(s). Relevant report(s) is/are/not attached (please delete where inappropriate).

_____

_____

_____

_____

_____

5. Welfare service(s) received/receiving by applicant

Month/Year	Name of Service Centre	Type of Service	Reason(s) for Discharge

6. Challenging behaviour, including (please select whichever appropriate):

☐ Offensive behaviour e.g. screaming, regurgitating, noisy behaviour, smearing with faeces or any similar offensive or antisocial habits, etc.

☐ Self-abusive behaviour e.g. biting self, eye-poking, scratching self, picking at sores, slapping self or similar behaviours resulting in self harm, etc.

☐ Aggression toward others, i.e. causing bodily harm in others (with or without weapon)

☐ Destructive behaviour, i.e. causing damage to furniture, fittings, buildings, vehicles, etc.

☐ Inappropriate sexual behaviour e.g. exposes self, masturbates or groping others in public, etc.

☐ Repetitive behaviour e.g. rocking of body back and forth, flapping hands, flicking fingers, pacing up and down, constant running, or other stereotyped behaviours, etc.

Please provide a detailed description on the behaviour, the context where it happened, its severity and frequency, treatment made and whether any improvement is observed.

_____

_____

_____

_____

_____

7. Present accommodation arrangement and description of home living environment.

_____

_____

_____

_____

_____

8. Any deterioration in carer's physical/mental health condition, and his/her present capability to look after applicant.

_____

_____

_____

_____

_____

9. Whether applicant is exposed to any physical/moral danger, and what kind of intervention is made.

_____

_____

_____

_____

_____

10. Reason(s) for priority placement (for priority placement in residential service, justification for not staying in present accommodation should also be provided).

_____

_____

_____

_____

_____

Recommended by

Signature: _____ Post Title: _____

Name: _____ Date: _____

11. Comment by Supporting Officer:

_____

_____

_____

_____

_____

Supported by*

Signature: _____ Tel.: _____

Name: _____ Fax: _____

Post Title: _____ Date: _____

*Endorsement should be obtained from agency head/designated representative of non-governmental organisation, principal of special school, or DSWO/ADSWO of SWD.

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Outcome of Application for Priority Placement

From: Central Referral System for Rehabilitation Services
Subsystem for Small Group Home for Children with Mild Intellectual Disabilities
(CRSRehab-SGHCMID)
Social Welfare Department
Room 901, 9/F Wu Chung House, 213 Queen's Road East
Wanchai, Hong Kong

To:

CRSRehab Tel.: Your Ref.:
Fax: Your Tel:
Date: Your Fax:

Name of applicant:

HKBC:

CRSRehab No.:

☐ I am pleased to inform you that your application for priority placement for the above-named applicant is approved. The particulars of the placement are detailed below:

Type of Placement:

Date of Priority Assigned:

Location preference:

☐ The captioned application for priority placement is not approved or not necessary due to the following reason:

If you have any question, please contact the undersigned for discussion on the case.

( )
Oi/c CRSRehab - SGHCMID

Forms of the Subsystem for the Supported Employment Training for Persons with Disabilities (CRSRehab-SET)

RESTRICTED

Central Referral System for Rehabilitation Services
Subsystem for the Supported Employment Training for Persons with Disabilities (CRSRehab-SET)
Registration Form

Part I

A. Source of Referral

Case ref. no.: _____ Tel.: _____

Name of referrer: _____ Fax.: _____

Office/Centre: _____ Date: _____

Please tick and confirm below –

Declaration

☐ Referrer has declared that there is no conflict of interest in handling this application. Referrer is not a family member or personal friend of the applicant and has no personal or social ties with the applicant.

B. Personal Particulars

1. Name: _____ _____
(English) *(Chinese)*

2. Sex: ☐ Male ☐ Female

3. Date of Birth: ____ *(dd)* ____ *(mm)* ____ *(yyyy)*

4. HKIC No.: _____ ( ) *or* L/M ( ) in RP 3/3/220/ (_____)

5. Residential District:

Hong Kong and Islands
☐ Central and Western ☐ Eastern ☐ Southern ☐ Wanchai
☐ Islands

Kowloon
☐ Kwun Tong ☐ Wong Tai Sin ☐ Kowloon City ☐ Mongkok
☐ Shamshuipo ☐ Yaumatei ☐ Tseung Kwan O ☐ Sai Kung

New Territories
☐ Kwai Tsing ☐ Tsuen Wan ☐ Tuen Mun ☐ Yuen Long
☐ Tin Shui Wai ☐ Tai Po ☐ Shatin ☐ Ma On Shan
☐ North (Sheung Shui and Fanling)

C. Disability

(i) Major disability (Please select ONLY ONE disability from the following 1 to 7)

1. Ex-mental Illness ☐ diagnosis: _____

2. Intellectual Disability ☐ A: Severe ☐ B: Moderate
☐ C: Mild ☐ D: Others, please specify diagnosis:_____
Date of psychological assessment: ☐☐ *(dd)* ☐☐ *(mm)* ☐☐☐☐ *(yyyy)*

3. Physical Disability ☐ please specify: _____

4. Hearing Impairment ☐ A: Deaf ☐ B: Partially impaired

5. Visual Impairment ☐ A: Blind ☐ B: Partially impaired

6. Visceral Disability ☐ please specify: _____

7. Other Disability ☐ please specify: _____

(iii) Additional information

8. Spastics/ cerebral palsy ☐ A: Spastic ☐ B: Cerebral palsy ☐ N: Not spastic or cerebral palsy

9. Epilepsy ☐ A: Yes (Under control/Not under control*) ☐ N: Not epilepsy

10. Mobility ☐ A: Walk unaided ☐ B: Walk with escort ☐ C: Walk with rehabaid
☐ D: Wheelchair bound ☐ E: Bed ridden

11. Ability to climb stairs/ slope ☐ A: Capable to climb stairs/slope by self
☐ B: Climb stairs/slope with other assistance
☐ C: Unable to climb stairs/slope even with other assistance

12. Public transport (Excluding taxi) ☐ A: Manage without escort ☐ B: Manage with escort
☐ C: Cannot manage with escort

13. Medication ☐ A: With medication, please specify: _____
☐ B: Without medication. ☐ C: Unknown

14. Treatment required (May ✓more than one) ☐ A: Occupational therapy ☐ B: Physiotherapy ☐ C: Psychiatric follow-up
☐ D: Others, please specify: _____ ☐ E: Nil

15. Rehabaid used (May ✓more than one) ☐ A: Wheelchair ☐ B: Ambulator ☐ C: Prosthesis/artificial legs ☐ D: Calipers
☐ E: Special boots ☐ F: Hearing aid ☐ G: Crutches ☐ H: Tripod
☐ I: Others, please specify: _____ ☐ J: Nil

***** to delete as appropriate

D. Education/Training/Employment record

1. Education Level ☐ A: Kindergarten ☐ B: Primary ☐ C: Secondary ☐ D: Post-secondary
☐ E: Special school ☐ F: No schooling ☐ G: Unknown

2. Present status ☐ A: Sheltered worker, (name of sheltered workshop: _____)

(*for CRSRehab-SET use* _____)

☐ B: Special school student ☐ C: VTC student ☐ D: Open employment

☐ E: Staying at home ☐ F : Psychartic day hospital ☐ G : Others, please specify: _____

3. Vocational training received ☐ N: No ☐ A: Yes, please specify:_____

4. Sheltered workshop attended ☐ N: No ☐ A: Yes

E. Financial assistance received

1. Receiving CSSA ☐ N: No ☐ A: Yes (CSSA No.: _____)

2. Receiving DA ☐ N: No ☐ A: Yes (DA No.: _____)

F. Location preference

☐ No

☐ Yes (*indicate **3 choices** in region/district/service unit if applicant has preferences other than his/her residential district. Remarks: choice in district will be offered only if SET unit(s) is/are available in the district*)

Description

1. _____ 2. _____

3. _____

Part II

A. Particular of family members /close relatives (living together with applicant)

Name	Relationship with applicant	Sex	Age/Year of birth

B. Home address: _____ **Tel. No**.:_____

C. Employment record

Period	Name of Company	Position/Duties	Wages	Reason for leaving

D. Recommendations

(*General assessment of the vocational need and potentials of the applicant for open employment and suitability for supported employment training for PWD; priority placement if required e.g. upward movement from sheltered workshop*)

_____

_____

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Confirmation of Registration

From: Central Referral System for Rehabilitation Services
Subsystem for the Supported Employment Training for Persons with Disabilities
Social Welfare Department
6/F, West Coast International Building
290-296 Un Chau Street
Sham Shui Po
Kowloon

To:

CRSRehab-SET Tel.:	3586 3952	Your ref.:	
Fax:	3755 4946	Your Tel:	
Date:		Your Fax:	

The following applicant has been registered in CRSRehab–SET for supported employment training service. Please kindly verify the following data and use *Form 3* to amend/update the information if needed. For case enquiries, please contact the staff-on-duty at 3586 3952. For protection of private data, only enquiries from the referrers will be answered.

I. Personal Particulars

Name (English):	Sex:
HKIC:	Residential District:
Date of Birth:	

II. Disability

Ex-mental Illness:	Spastic/cerebral palsy:
Intellectual Disability:	Epilepsy:
Date of Assessment:	Mobility:
Physical Disability:	Climb Stair/Slope:
Hearing Impairment:	Medication:
Visual Impairment:	Public transport:
Visceral Disability:	Treatment required:
Other Disability:	Rehabaid used:

III. Placement Request

Type of placement:	Application date:
CRSRehab no.	Waiting List:
Location preference:	

( )
Oi/c CRSRehab-SET

限閱文件
RESTRICTED

社會福利署
康復服務中央轉介系統
申請康復服務登記書
Notification of Registration for Rehabilitation Services
Central Referral System for Rehabilitation Services
Social Welfare Department

/ /

致： 康復服務申請人（經個案社工／轉介者轉交）
To: Applicant (Via Caseworker/Referrer)

下列申請經已於社會福利署（社署）康復服務中央轉介系統內登記，詳情如下：
The following application has been registered in the Central Referral System for Rehabilitation Services of the Social Welfare Department (SWD) with details listed as below:

姓名：
Name: _____

香港身份證：
Hong Kong Identity Card: _____

申請日期：
Date of Application: _____

申請輪候的康復服務：
Rehabilitation Service(s) Applying for: _____

輪候狀況：
Status on Waiting List: _____

檔案號碼：
Your Reference: _____

申請人編號：
CRSRehab No.: _____

服務地區選擇：
Location Preference: _____

倘若你獲得編配所申請的服務，康復服務中央轉介系統將會透過你的社工／轉介者與你聯絡，安排接受有關服務。為令各方面保持緊密聯絡，若果你的聯絡地址、電話或所需的服務已轉變，請儘快通知個案社工／轉介者，以便他／她將有關資料轉達本系統。就上述服務的申請及轉介事宜，社署及轉介機構不會收取任何費用。若有人藉詞協助申請而索取利益，申請人應立即向廉政公署舉報。任何人意圖行賄，亦屬違法，社署會將個案轉介廉政公署查究。

Once you are selected for a placement in rehabilitation unit, the Central Referral System for Rehabilitation Services will inform you via the referring social worker to prepare for acceptance of placement offer. For maintaining good contacts among all parties concerned, please inform the referring social worker as early as possible if you have changes in your address, telephone number or rehabilitation services required, so that information may be updated at the Central Referral System for Rehabilitation Services. SWD and the referring agency will not charge for the application and referral for service. The applicant should report to the Independent Commission Against Corruption (ICAC) immediately in case anyone offers to assist in application for placement in return for remuneration. Attempted bribery by any person is also an offence in law, SWD will refer the case to ICAC for investigation.

如你對以上的申請有任何查詢，請與你的社工／轉介者聯絡：
Should you have any enquiry on the above application, you may contact your referring social worker:

社工／轉介者姓名：
Caseworker / Referral Name: _____

機構名稱：
Centre: _____

辦公室地址：
Office Address: _____

聯絡電話（內線）：
Phone Contact No. (ext.): _____

Data Updating Form

From: _____ *(Name of Referring Office)*	To: Central Referral System for Rehabilitation Services Subsystem for the Supported Employment Training for Persons with Disabilities Social Welfare Department 6/F, West Coast International Building 290-296 Un Chau Street Sham Shui Po Kowloon
_____ *(Name of Organisation)*	
_____ *(Address of Referring Office)*	
Ref.: _____	
Tel.: _____	
Fax: _____	Tel.: 3586 3952
Date: _____	Fax: 3755 4946

Name: _____ HKIC No.: _____ CRSRehab No.: _____

Information to be updated: (please ✓ in the appropriate box)

☐ Placement is no longer required. Case can be deleted from CRSRehab–SET.

☐ Change in placement request: _____

☐ Referring office is changed to: _____

☐ Applicant is discharged/ready for discharge* from hospital. Please put the case back on waiting list.

☐ Change in applicant's personal particulars (residential district, disability, etc.):

☐ Change in location preference:

1. _____
2. _____
3. _____

☐ Others, please specify:

Signature: _____

Name: _____

Post: _____

* *Please delete as appropriate*

c.c. New Referring Office (for reporting change of referring office):

RESTRICTED

Removal from Waiting List

From: Central Referral System for Rehabilitation Services
Subsystem for the Supported Employment Training for Persons with Disabilities
Social Welfare Department
6/F, West Coast International Building
290-296 Un Chau Street
Sham Shui Po
Kowloon

To:

CRSRehab-SET Tel.: 3586 3952 Your Ref.:
Fax: 3755 4946 Your Tel:
Date: Your Fax:

Name: ( )

HKIC:

CRSRehab No.:

The above-named application has been removed from the waiting list due to the following reason:

☐ Case closed in CRSRehab-SET upon:

☐ Hospitalisation of applicant. Please refer to the *Manual of Procedures* for CRSRehab for further information.

☐ Applicant being rejected twice by different agencies in the same service. Please arrange for re-assessment in the applicant's genuine service need.

( )
Oi/c CRSRehab-SET

Report of Vacancies

From: _____
(Name of Rehabilitation Unit)
_____
(Name of Organisation)
_____
(Address of Rehabilitation Unit)
Ref.: _____
Tel.: _____
Fax: _____
Date: _____

To: Central Referral System for Rehabilitation Services
Subsystem for the Supported Employment Training for Persons with Disabilities
Social Welfare Department
6/F, West Coast International Building
290-296 Un Chau Street
Sham Shui Po

Tel.: 3586 3952
Fax: 3755 4946

1. Number of vacancies as at _____ *(dd/mm/yyyy)*

(a) Capacity	
(b) Enrolment	
(c) No. of referral(s) approved and pending admission	
(d) No. of referral(s) being processed	
(e) No. of referral(s) CRSRehab-SET can send (a – b – c – d)	

2. Number of vacancies anticipated (excluding those reported in item 1):

Vacancies	
Available date(s)	
Remarks	

Signature: _____
Name: _____
Post: _____

RESTRICTED

Selection for Placement

From: Central Referral System for Rehabilitation Services
Subsystem for the Supported Employment Training for Persons with Disabilities
Social Welfare Department
6/F, West Coast International Building
290-296 Un Chau Street
Sham Shui Po
Kowloon

To:

CRSRehab-SET Tel.:	3586 3952	Your Ref.:	
Fax:	3755 4946	Your Tel:	
Date:		Your Fax:	

The following applicant has been selected for placement in a supported employment training unit with details shown below. Please reply to CRSRehab by *Form 7* **within 3 week(s)**.

Your early reply will facilitate the applicant's admission for service. You may consider contacting the supported employment training unit for arrangement of visits for the applicant or information on the service as appropriate. (For priority placement, please review and confirm the applicant still has urgent service need.)

Name of applicant:

HKIC:

CRSRehab No.:

Name of Rehabilitation Unit:

Type of Service:

Address:

Tel. No.:

Fax No.:

Date of Selection:

If the applicant accepts the placement offer, please send the following required papers to the supported employment training unit directly:

1. Form 1
2. Form 7
3. Medical report

( )
Oi/c CRSRehab-SET

Notification of Case Selection to Supported Employment Training Unit

From: Central Referral System for Rehabilitation Services
Subsystem for the Supported Employment Training for Persons with Disabilities
Social Welfare Department
6/F, West Coast International Building
290-296 Un Chau Street
Sham Shui Po
Kowloon

To:

CRSRehab-SET Tel.: 3586 3952 Your Tel:
Fax: 3755 4946 Your Fax:
Date:

Listed below for your information are the application(s) that have been selected from the waiting list for placement in your service unit. These applicants have 3 weeks' time to decide whether they accept the placement offer or not. Subject to their acceptance of placement offer, referrer will send relevant documents to you for case intake once they are available.

While the applicants are considering acceptance of placement offer, they and/or their family members may, through the referring officers, approach your unit for visits or information on services provided.

Since some of the applicants may eventually decline the placement offer, if you need updated referral situation of the above list, please contact the staff-on-duty of the CRSRehab-SET at 3586 3952.

Name	Sex/Age	CRSRehab No.	Referrer/Tel. No.	Normal/Priority

Please be reminded that your staff should have declared that there is no conflict of interest in handling the application(s). They are not a family member or personal friend of the applicant and have no personal or social ties with the applicant.

( )
Oi/c CRSRehab-SET

RESTRICTED

Reply to CRSRehab-SET on Selection for Placement

From:

_____
(Name of Referring Office)

_____
(Name of Organisation)

_____
(Address of Referring Office)

Ref.: _____

Tel.: _____

Fax: _____

Date: _____

To: Central Referral System for Rehabilitation Services
Subsystem for the Supported Employment Training for Persons with Disabilities
Social Welfare Department
6/F, West Coast International Building
290-296 Un Chau Street
Sham Shui Po
Kowloon

Tel.: 3586 3952

Fax: 3755 4946

Application for Admission to *(name of supported employment training unit)*: _____

Name: _____ ID No.: _____ CRSRehab No.: _____

☐ **Applicant accepts the offer**. (For priority placement, the applicant is confirmed to have urgent service need.)

The following documents will be sent by the referrer to the supported employment training unit.:

- ☐ CRSRehab–SET Form 1
- ☐ School progress/VTC * report
- ☐ Psychological/psychiatric * report
- ☐ Medical report
- ☐ Others, please specify: _____

☐ **Applicant declines the offer** (Please ✓ only one box):

- ☐ Applicant considers the location of supported employment training unit unfavourable.
- ☐ No immediate need for service.
- ☐ Transport not available/cannot be arranged.
- ☐ Applicant left Hong Kong or emigrated overseas.
- ☐ Lost contact with applicant.
- ☐ Applicant passed away.
- ☐ Applicant is engaged in open employment at present.
- ☐ The placement offer does not match applicant's location preference.
- ☐ Change of service type required due to deterioration of ability. Placement is no longer required.
- ☐ Others, please specify: _____

☐ **Applicant is temporarily hospitalised.**

Name of Hospital:
Admission date:
Diagnosis/Treatment required:

Signature: _____

Name: _____

Post: _____

** Please delete as appropriate*

Reminder to Referrer

From: Central Referral System for Rehabilitation Services
Subsystem for the Supported Employment Training for Persons with Disabilities
Social Welfare Department
6/F, West Coast International Building
290-296 Un Chau Street
Sham Shui Po
Kowloon

To:

CRSRehab-SET Tel.: 3586 3952 Your Ref.:
Fax: 3755 4946 Your Fax:
Date:

Name of applicant:

HKIC No.:

CRSRehab No.:

Date of Selection :

Name of SET Unit :

CRSRehab–SET has not received your reply to the placement offer for the above-named applicant. I would be grateful if you would reply to CRSRehab–SET via *Form 7* within **2 weeks**. Otherwise, the applicant would be removed from the waiting list.

If you have already replied to this, I would much appreciate if you would forward a copy of *Form 7* to CRSRehab–SET.

( )
Oi/c CRSRehab-SET

c.c. ADSWO( ) (for SWD Staff)
Agency Head (for NGO Staff)

RESTRICTED

Referral for Admission

From: Central Referral System for Rehabilitation Services
Subsystem for the Supported Employment Training for Persons with Disabilities
Social Welfare Department
6/F, West Coast International Building
290-296 Un Chau Street
Sham Shui Po
Kowloon

To:

CRSRehab-SET Tel.: 3586 3952 Your Tel:
Fax: 3755 4946 Your Fax:
Date:

Referral for Admission to

_____

Please be informed that the following applicant is referred for admission to your unit. Please kindly reply CRSRehab-SET by *Form 9* within 21 day(s).

Case particulars:

Name of applicant: Hong Kong Identity Card.:

Gender / D.O.B.: CRSRehab No.:

By copy of this, the referrer is requested to contact the supported employment training unit for case intake and pass the following referral papers to the unit.

1. Form 1
2. Form 7
3. Psychiatric report (for PMR)

( )
Oi/c CRSRehab-SET

c.c. Referring office (without enclosure):
(case ref.)

Report on Case Intake/Discharge

From: _____
(Name of Rehabilitation Unit)
_____
(Name of Organisation)
_____
(Address of Rehabilitation Unit)
Ref.: _____
Tel.: _____
Fax: _____
Date: _____

To: Central Referral System for Rehabilitation Services
Subsystem for the Supported Employment Training for Persons with Disabilities
Social Welfare Department
6/F, West Coast International Building
290-296 Un Chau Street
Sham Shui Po
Kowloon

Tel.: 3586 3952
Fax: 3755 4946

1. Case information

Name: _____ HKIC No.: _____ CRSRehab No.: _____

2. Please be informed that the above-named case has been:

☐ admitted into service on _____ *(date)*.

☐ unable to be admitted into service as there is no vacancy.

☐ rejected upon case screening due to:
- ☐ fail in job test
- ☐ low ability/motivation for training
- ☐ health problem
- ☐ unstable mental/emotional condition
- ☐ severe behavioral problem (please specify):
- ☐ others (please specify):

☐ self-withdrawn by applicant upon case screening due to:
- ☐ open employment
- ☐ unfavourable location
- ☐ lost trace
- ☐ applicant do not disclose any reason
- ☐ others (please specify):_____

☐ discharged from our service on _____ *(dd/mm/yyyy)* due to:
- ☐ successfully discharge (i.e meeting the criteria of FSA)
- ☐ unsuccessful discharge on ___ , please specify reason:
- ☐ others (please specify):

Signature: _____
Name: _____
Post: _____

c.c. Referring office:
(case ref.)

Reminder to Rehabilitation Unit

From: Central Referral System for Rehabilitation Services
Subsystem for the Supported Employment Training for Persons with Disabilities
Social Welfare Department
6/F, West Coast International Building
290-296 Un Chau Street
Sham Shui Po
Kowloon

To:

CRSRehab-SET Tel.: 3586 3952 Your Tel:
Fax: 3755 4946 Your Fax:
Date:

The following application(s) has /have been referred to your unit for consideration of admission for more than 3 weeks. So far, no reply has been received by CRSRehab. I would be grateful for your prompt decision on this/ these application(s) and reply to CRSRehab via *Form 9* with a copy to the referrer concerned **within 2 weeks**.

Date of Referral	CRSRehab No.	Name of Applicant	Sex	Age

( )
Oi/c CRSRehab-SET

c.c. Agency Head
Referrer:

Application for Priority Placement

From: _____
(Name of Referring Office)
_____
(Name of Organisation)
_____
(Address of Referring Office)
Ref.: _____
Tel.: _____
Fax: _____
Date: _____

To: Central Referral System for Rehabilitation Services
Subsystem for the Supported Employment Training for Persons with Disabilities
Social Welfare Department
6/F, West Coast International Building
290-296 Un Chau Street
Sham Shui Po
Kowloon

Tel.: 3586 3952
Fax: 3755 4946

1. Case particulars

Name: _____ Sex/D.O.B.: _____ HKIC No.: _____

Address: _____ Tel.: _____

Disability: _____

Placement required: _____ CRSRehab No.: _____

2. Particulars of family members and relatives

Name	Relationship	Sex/Age	Occupation/ schooling	Income/ school fee	Disability/ill health (if any)	Remarks

3. Case/Family background

_____

_____

_____

_____

4. Reasons for priority placement

_____

_____

_____

_____

Prepared by
Signature: _____
Name: _____
Post: _____

Endorsed by*
Signature: _____
Name: _____
Post: _____

* Endorsement should be obtained from agency head/designated representative of non-governmental organisation or DSWO/ADSWO of SWD.

Outcome of Application for Priority Placement

From: Central Referral System for Rehabilitation Services
Subsystem for the Supported Employment Training for Persons with Disabilities
Social Welfare Department
6/F, West Coast International Building, 290-296 Un Chau Street,
Sham Shui Po, Kowloon

To:

Your Ref.:
Date:

CRSRehab-SET Tel.: 3586 3952
Fax: 3755 4946

Name:

HKIC No.:

CRSRehab No.:

☐ I am pleased to inform you that your application for priority placement for the above-named applicant is approved. The particulars of the placement application is detailed below:

Type of Placement:
Date of Priority Assigned:
Location preference:

☐ The captioned application for priority placement is not approved or not necessary due to the following reason:

☐ Placement had already been offered to _____ on _____

☐ The case situation does not merit accelerated placement ahead of others.

If you have any question, please contact the staff-on-duty at 3586 3952 for discussion on the case.

( )
Oi/c CRSRehab-SET

Central Referral System for
Rehabilitation Services (CRSRehab)

Forms of the Subsystems

Rehabilitation & Medical Social Services Branch
Social Welfare Department
https://www.swd.gov.hk/tc/pubsvc/rehab/cat_crsrehab/centralref/