

# **Central Referral System for Rehabilitation Services (CRSRehab)**

## **Manual of Procedures**

## Table of Contents

---

<b>Chapter I</b>	<b>Overview.....</b>	<b>1</b>
<b>Chapter II</b>	<b>Normal Referral Procedures.....</b>	<b>4</b>
	<i>Workflow in the Referral Process</i>	4
	<i>Case Registration</i>	9
	<i>Location Preference</i>	11
	<i>Updating of Case Information</i>	11
	<i>Change of Service/Addition of Service</i>	12
	<i>Transfer of Application from Waiting List of Residential Rehabilitation Service to Inactive Waiting List and Vice Versa under CRSRehab-MPH</i>	12
	<i>Change of Application from CRSRehab residential service to Infirmary and Backdating Arrangement</i>	14
	<i>Offer of Placement</i>	16
	<i>Placement out of Applicant's Preference</i>	16
	<i>Case Processing by the Referrer Upon Selection for Placement</i>	16
	<i>Essential Documents for Processing of Applications</i>	18
	<i>Reminder to Referrers</i>	19
	<i>Hospitalisation of Case</i>	19
	<i>Request for Non-activation</i>	20
	<i>Case Deletion/Re-application</i>	20
	<i>Report of Vacancy</i>	20
	<i>Case Intake by Rehabilitation Units</i>	21
	<i>Rejection of Cases</i>	22
	<i>Cases Admitted into the Rehabilitation Units</i>	22
	<i>Removal from the Waiting List</i>	23
<b>Chapter III</b>	<b>Major Issues in the Referral Process .....</b>	<b>24</b>
	<i>Continuation of Study (COS)</i>	24
	<i>Extension of Years of Study (EoS) for Students of Aided Special School</i>	25
	<i>Re-activation of Application under CRSRehab</i>	25
	<i>Priority Placement</i>	26
	<i>Case Swapping</i>	28
	<i>Appeal Against Decision Made by Rehabilitation Units</i>	28

<b>Chapter IV</b>	<b>Roles and Responsibilities .....</b>	<b>29</b>
	<i>Roles and Responsibilities of Referrers</i>	29
	<i>Roles and Responsibilities of Rehabilitation Units</i>	30
	<i>Roles and Responsibilities of CRSRehab</i>	30
	<i>Roles and Responsibilities of Social Work Officers (Rehabilitation&amp;Medical Social Services)</i>	31
	<i>Roles and Responsibilities of Assistant District Social Welfare Officers/District Social Welfare Officers/ Agency Heads</i>	31
<b>Chapter V</b>	<b>Frequently Asked Questions .....</b>	<b>32</b>
	<i>Services for the Mentally/Physically Handicapped</i>	32
	<i>Services for the Ex-Mentally Ill</i>	34
	<i>Services for the Aged Blind</i>	35
	<i>Services for Mildly Mentally Handicapped Children</i>	35
	<i>Supported Employment Service</i>	36
<b>Chapter VI</b>	<b>CRSRehab Forms .....</b>	<b>37</b>
	<i>Overview of the Forms of the Central Referral System for Rehabilitation Services</i>	37
	<i>Forms of CRSRehab-MPH</i>	
	<i>Forms of CRSRehab-ExMI</i>	
	<i>Forms of CRSRehab-AB</i>	
	<i>Forms of CRSRehab-SGHMMHC</i>	
	<i>Forms of CRSRehab-SE</i>	
	<i>Day/Residential Service for Mentally or Physically Handicapped Persons – Medical Examination Form</i>	
	<i>Visual Examination Form for Admission to Care &amp; Attention Home for the Aged Blind</i>	

### **Appendices**

<i>Appendix 1</i>	<i>Summary of Procedures on Central Referral System for Rehabilitation Services</i>
<i>Appendix 2a</i>	<i>Notes of Application for Rehabilitation Services Under Central Referral System for Rehabilitation Services – Subsystem for the Mentally/Physically Handicapped (CRSRehab- MPH)</i>

- Appendix 2b*      *Notes of Application for Rehabilitation Services Under Central Referral System for Rehabilitation Services – Subsystems for the Aged Blind (CRSRehab-AB) / Ex-mentally Ill (CRSRehab-ExMI) / Small Group Home for Mildly Mentally Handicapped Children (CRSRehab-SGHMMHC)*
- Appendix 2c*      *Notes of Application for Rehabilitation Services Under Central Referral System for Rehabilitation Services – Subsystem for the Mentally/Physically Handicapped (CRSRehab-SE)*
- Appendix 3*        *Information Paper on the “Validity” of a Clinical Psychological Report*
- Appendix 4*        *Procedures for Change of Application from CRSRehab residential service to Infirmary and Backdating Arrangement*
- Appendix 5*        *Referral for Infirmary Service*
- Appendix 6*        *Transfer of cases to Inactive Waiting List under CRSRehab-MPH*
- Appendix 7*        *Transfer of cases from Inactive Waiting List to Active Waiting List under CRSRehab-MPH*
- Appendix 8*        *Screening and Processing Admission to RCHD under CRSRehab-MPH*

## Chapter I Overview

1.1 The Central Referral System for Rehabilitation Services (CRSRehab) covers rehabilitation services for disabled pre-schoolers, mildly mentally handicapped children, mentally and/or physically handicapped persons, ex-mentally ill persons, and the aged blind persons in day training and residential care. Rehabilitation services that can be waitlisted at CRSRehab are summarised in the following table:

Age	0 to 6	6 to 18	15 and above			60 and above
Target group	Disabled Pre-schoolers	Mentally Handicapped	Mentally Handicapped	Physically Handicapped	Ex-mentally Ill	Aged Blind
Subsystem	CRSRehab-PS	CRSRehab-SGHMMHC	CRSRehab-MPH		CRSRehab-ExMI	CRSRehab-AB
Day Training	Early Education and Training Centre		Supported Employment (SE)/Sheltered Workshop (SW) <sup>i/</sup> Integrated Vocational Rehabilitation Services Centre (IVRSC)			
	Special Child Care Centre		Day Activity Centre (DAC)			
	Integrated Programme in Kindergarten-cum-Child Care Centre					
	On-site Pre-school Rehabilitation Services					
Residential Service	Residential Special Child Care Centre	Small Group Home for Mildly Mentally Handicapped Children	Supported Hostel (SHOS) <sup>ii</sup>			Care & Attention Home for the Aged Blind
		Integrated Small Group Home	Hostel for Moderately Mentally Handicapped Persons <sup>ii</sup> (HMMH)		Halfway House <sup>ii</sup> (HWH)	
	Hostel for Severely Mentally Handicapped Persons (HSMH)		Hostel for Severely Physically Handicapped Persons (HSPH)	Halfway House (with Special Provision) <sup>ii</sup> (HWH-SP)		
			Hostel for Severely Physically Handicapped Persons with Mental Handicapped		Long Stay Care Home <sup>ii</sup> (LSCH)	
	Care & Attention Home for Severely Disabled Persons (C&A/SD)					

<sup>i</sup> Includes the Factory for the Blind, operated by the Hong Kong Society for the Blind.

<sup>ii</sup> Under the Bought Place Scheme (BPS) for Private Residential Care Home for Persons with Disabilities, service places of Bought Place Providing High Level of Care (Category 1) (BH1) and Bought Place Providing High Level of Care (Category 2) (BH2) are offered to the applicants on the waiting lists for LSCH or HMMH, while service places of Bought Place Providing Medium Level of Care (BM) are offered to the applicants on the waiting lists for HWH or SHOS in accordance to their indication of acceptance of BPS.

1.2 The Co-ordinated Referral System for Disabled Pre-schoolers (CRSPS) and the Central Referral System for Disabled Adults (CRSDA) were established by the Social Welfare Department (SWD) in 1987 and 1988 respectively. These two referral systems have been incorporated together since April 2000 and renamed as the **Central Referral System for Rehabilitation Services (CRSRehab)** to:

- a) ensure uniformity in the referral procedures and the admission criteria of services by centralising referrals and placements;
- b) ensure efficient utilisation of provisions and to minimise the waiting time by engineering cross district/region placement as need arises;
- c) ensure referrals for and placements in the most appropriate type of services in the light of existing policy and admission criteria;
- d) ensure clients' smooth transition and continuity from one type of service to another in case of developmental or circumstantial changes;
- e) ensure that existing services be made available to appropriate disability groups and set priority for priority placements on a need basis; and
- f) provide information and statistical data on enrolment and waiting list for demand assessment and planning purpose.

1.3 The CRSRehab was originally composed of 4 subsystems that cater for persons with different disabilities upon inception. It has been further expanded to include a new waiting list on Small Group Home for Mildly Mentally Handicapped Children / Integrated Small Group Home in 2000 and Supported Employment (SE) service in October 2000. Currently, the subsystems under CRSRehab include:

Subsystem for Disabled Pre-Schoolers (CRSRehab-PS)

Subsystem for the Mentally/Physically Handicapped (CRSRehab-MPH)

Subsystem for the Ex-mentally Ill (CRSRehab-ExMI)

Subsystem for the Aged Blind (CRSRehab-AB)

Subsystem for Small Group Home for Mildly Mentally Handicapped Children (CRSRehab-SGHMMHC)

Subsystem for the Supported Employment (CRSRehab-SE)

1.4 The contact telephone numbers for general enquiries for the respective subsystems are summarised as below:

Subsystem	Contact Tel. No.	
CRSRehab-PS	2892 5139 / 2892 5569	
CRSRehab-MPH	DAC/HSMH/C&A/SD	3586 3809
	SW/IVRSC/SHOS/HMMH/HSPH	3586 3826
	Inactive Waitlisting Mechanism	3422 3995
CRSRehab-SE	3586 3952	
CRSRehab-ExMI	2892 5134 / 2892 5347	
CRSRehab-AB		
CRSRehab-SGHMMHC		

1.5 Description of available services and the admission criteria are detailed in the Homepage of SWD ([https://www.swd.gov.hk/en/index/site\\_pubsvc/page\\_rehab/](https://www.swd.gov.hk/en/index/site_pubsvc/page_rehab/)).

1.6 For CRSRehab-PS, please refer to the Manual of Procedures of Central Referral System for Rehabilitation Services-Subsystem for Disabled Pre-schoolers [October 2018 (Revised Edition)].

## Chapter II Normal Referral Procedures

### Workflow in the Referral Process

2.1 The referral procedures are summarised in the following table:

Step	Action	By	Time Frame	Form Used
<b>Case identification</b>				
1	To assess the applicant's need for rehabilitation services	Referrer		
<b>Case registration and data updating</b>				
2	To waitlist the applicant for the appropriate service in CRSRehab	Referrer		<i>Form 1</i>
3	To register the applicant in the waiting list and to notify the referrer of the registration	CRSRehab	14 working days after receiving the completed <i>Form 1</i>	<i>Form 1A, Form 1B</i> For CRSRehab-MPH: <i>Form 1A, Form 1B and Notification of Assessment Result</i>
4	To conduct regular case review to ensure that the applicant is waitlisting for appropriate service(s) and to update CRSRehab any change of the applicant relating to the application	Referrer		<i>Form 3</i>
5	To register the changes in CRSRehab and to notify the referrer of the changes which had been registered	CRSRehab	14 working days after receiving the completed <i>Form 3</i>	For updating of changes: <i>Form 1A, Form 1B</i> CRSRehab-MPH: <i>Form 1A, Form 1B and Notification of Assessment Result</i> For cases removed from CRSRehab : <i>Form 4</i> CRSRehab-MPH: <i>Form 4 and Form 1C</i>
6	Transfer of cases between the Active Waiting List (AWL) and the Inactive Waiting List (IWL) under CRSRehab-MPH			
	a To inform CRSRehab if the applicant opt to IWL with his/her application date of residential or paired-up day and residential rehabilitation services be retained	Referrer		<i>Form 3</i>  Please refer to para. 2.13 for details
	b To transfer the applicant to the IWL and to notify the referrer of the case transfer	CRSRehab	14 working days after receiving <i>Form 3</i>	<i>Form 4A and Annex to Form 4A</i> "Letter to applicants applying for transfer to the IWL"
	c To remind the referrers to conduct annual review for applications on the IWL	CRSRehab		<i>Form 7C</i>

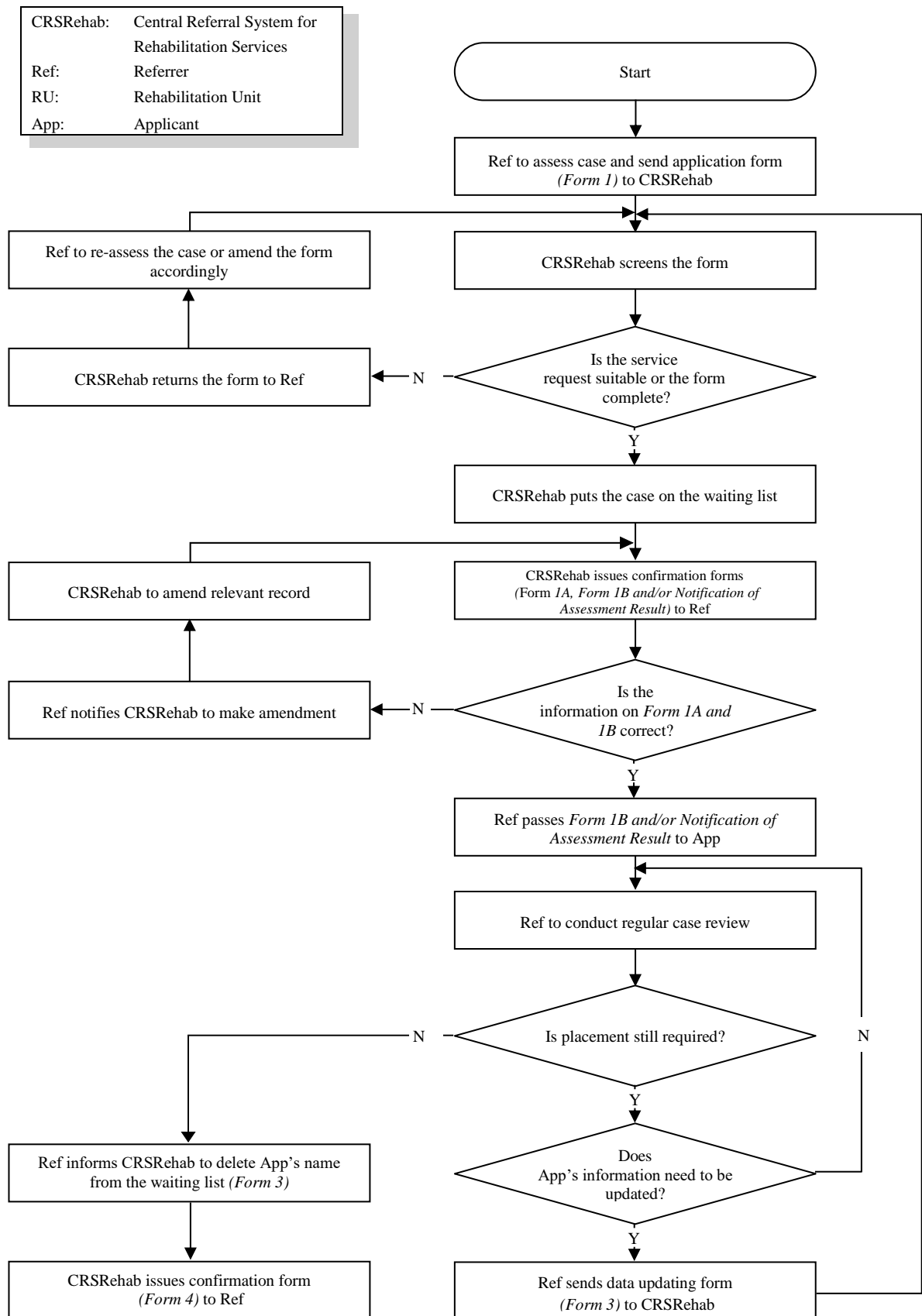


Step	Action	By	Time Frame	Form Used
	d To conduct annual review on applications on the IWL and to inform CRSRehab if the applicant would like to remain on the IWL continuously or to reactivate his/her application	Referrer	3 weeks	For applications to be remained on the IWL → <i>Form 3</i>  For cases to be reactivated and returned to AWL: Change in health condition? (If Yes → <i>Form 3 + Form 1</i> ) (If No → <i>Form 3 + Form 1D</i> )  Please refer to para. 2.16 for details
	e To put the applicant requesting reactivation of his/her application back to the AWL and notify the referrer of the change	CRSRehab	14 working days after receiving <i>Form 3 + Form 1 / Form 1D</i>	<i>Form 1A, Form 1B and Notification of Assessment Result</i>
<b>Notification of vacancy</b>				
7	To confirm in writing with CRSRehab of the vacancy	Rehabilitation unit	Within 3 working days after a vacancy is identified	<i>Form 5</i>
<b>Case selection</b>				
8	To select the appropriate applicants from the waiting list and inform the referrers and rehabilitation units of the case selection	CRSRehab	3 working days	<i>Form 6 and/or Form 6A</i>
<b>Case processing by referrer upon selection to placement</b>				
9	To inform CRSRehab (for CRSRehab-ExMI, also the rehabilitation unit concerned) whether the placement is accepted by the applicant	Referrer	3 weeks  2 weeks	CRSRehab-MPH/AB/SGHMMHC: <i>Form 7</i> to CRSRehab and attach relevant documents if applicant accepts the placement.  SE : <i>Form 7</i> to CRSRehab-SE and relevant documents to SEU directly  ExMI : <i>Form 7</i> to CRSRehab-ExMI, relevant documents to rehabilitation units directly.
10	For CRSRehab-MPH : To inform CRSRehab if the applicant would like to be transferred to IWL with his/her application date of residential or paired-up day and residential rehabilitation services be retained	Referrer	3 weeks	<i>Form 7</i>  Please refer to para. 2.14 for details
11	For CRSRehab-MPH : To transfer the applicant to IWL and notify the referrer of the change	CRSRehab	14 working days after receiving <i>Form 7</i>	<i>Form 4A and Annex to Form 4A "Letter to applicants applying for transfer to the IWL"</i>
12	To issue reminder(s) to referrer for delayed cases and to close those cases with no response	CRSRehab		CRSRehab-MPH/AB/SGHMMHC /SE : <i>Form 7A</i>  CRSRehab-ExMI : <i>Form 7A and/or 7B</i>  Please refer to para. 2.25 for details

Step	Action	By	Time Frame	Form Used
<b>Case intake by rehabilitation unit</b>				
13	To process the referral and inform the result to the CRSRehab and the referrer	Rehabilitation unit	CRSRehab-MPH/AB/SGHMMHC: 4 weeks CRSRehab-ExMI: 2 weeks CRSRehab-SE 3 weeks	<i>Form 9</i> with a copy to the referrer
14	To issue reminder(s) to rehabilitation units for delayed cases	CRSRehab		CRSRehab-MPH/AB/SGHMMHC/SE : <i>Form 9A</i> CRSRehab-ExMI : <i>Form 9A</i> and/or <i>9B</i>  Please refer to para. 2.31 for details

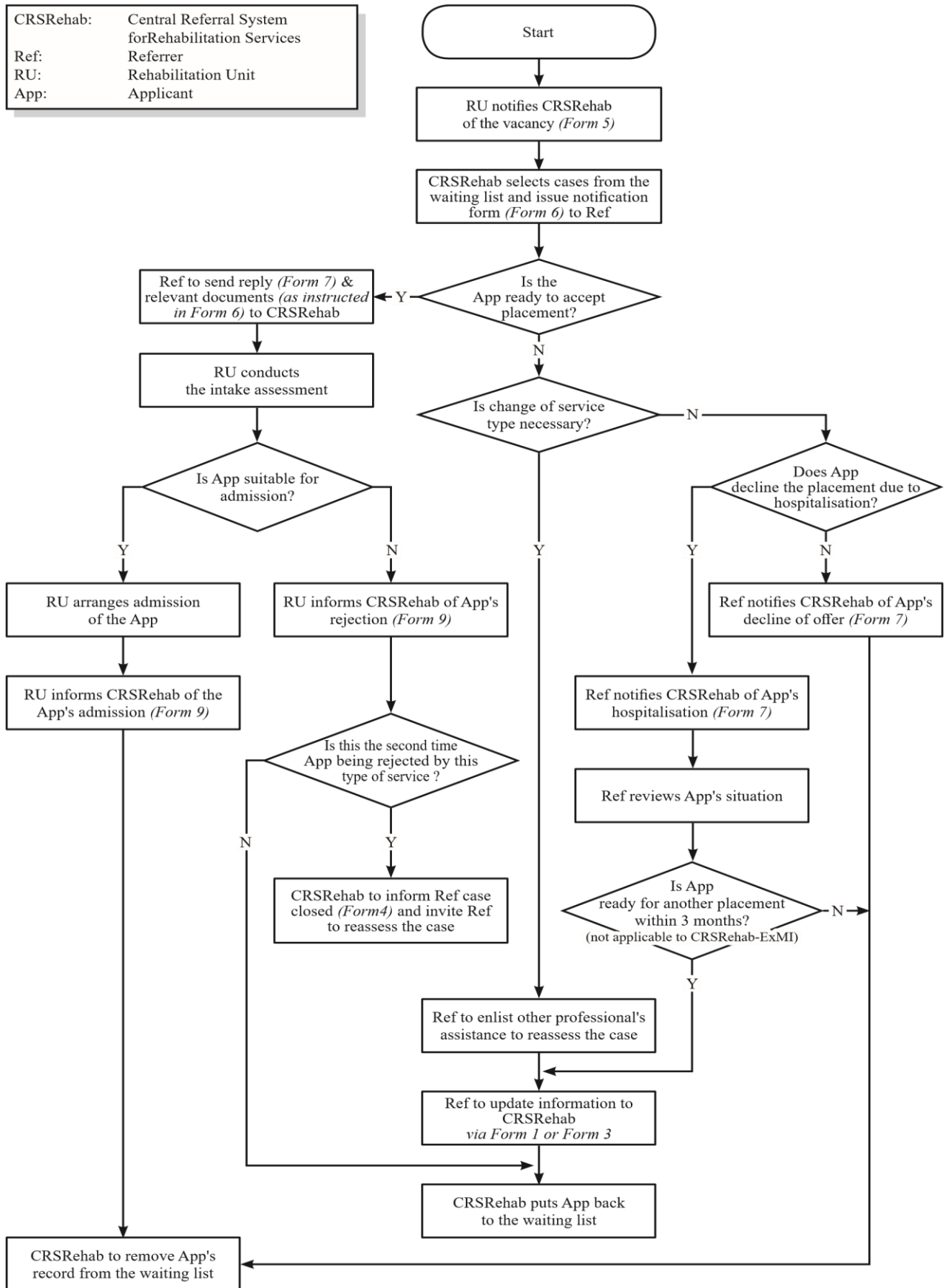
2.2 An overview of the workflow in the application and selection process is summarised in the flowcharts in Figure 1 and 2.

**Figure 1: New Application and Data Updating Process**



Note : Please refer to Appendix 6 to Appendix 8 for cases in need of transfer to the Inactive Waiting List under CRSRehab-MPH.

**Figure 2: Case Selection and Admission Process**



Note : Please refer to Appendix 6 to Appendix 8 for cases in need of transfer to the Inactive Waiting List under CRSRehab-MPH.

## Case Registration

2.3 Before making an application to CRSRehab, a referrer should arrange for the assessment(s) from relevant professionals in order to ensure that the applicant is eligible for the rehabilitation service to be applied for. These assessments include:

<b>Disability Group</b>	<b>Assessment to be Conducted by</b>
Mentally Handicapped Persons	Clinical psychologist or educational psychologist #
Ex-mentally Ill Persons	Psychiatrist or medical officer in psychiatric unit
Aged Blind Persons	Medical officer in eye clinic/eye hospital or privately practised ophthalmologist
Physically Handicapped*, Visually / Hearing Impaired and Viscerally Disabled Persons	Medical practitioner, ophthalmologist, audiologist, etc.

# Intellectual report for Mentally Handicapped Persons issued by medical officer is not accepted. The referrer has to provide the intellectual report when placement is offered.

\* The referrer has to provide the medical report when applying for service for physically handicapped persons.

2.4 Applicants with mental and/or physical handicap may have to submit additional document(s) together with the CRSRehab-MPH *Form 1* if they would like to apply for the following services :

	<b>Application for DAC</b>	<b>Application for SW/IVRSC</b>
Mild Grade Mental Retardation	Report from Occupational Therapist done within 12 months before submission of the application	Report from Occupational Therapist / Physiotherapist done within 12 months before submission of the application, or Clinical / Educational Psychologist with assessment done after 6 years of age
Moderate Grade Mental Retardation	Report from Occupational Therapist done within 12 months before submission of the application	Not required
Severe Grade or Profound Mental Retardation	Not required	Not required
Physically Handicapped only	Not applicable	Not required

2.5 After the service need(s) of the applicant has/have been ascertained by relevant assessment(s), the referrer should explain to the applicant/family member(s)/carer(s)/guardian the criteria in the application for rehabilitation services via the “Notes of Application for Rehabilitation Services” (Appendix 2a/2b/2c) as appropriate and request him/her/them to sign on the lower portion of the Notes. A copy of the Notes signed by the applicant/family member(s)/carer(s)/guardian should be retained by the referrer on file for record purpose, and thereafter the referrer may make application via *Form 1* to CRSRehab for appropriate service(s). Due to the wide variety of rehabilitation services under CRSRehab, there are different application forms to be used when making application for different types of rehabilitation services. The referrer should be careful in choosing the appropriate form when making an application for their customers. An overview of the forms of the subsystems (excluding CRSRehab-PS) is detailed at Chapter VI. For forms of CRSRehab-PS, please refer to the Manual of Procedures of Central Referral System for Rehabilitation Services-Subsystem for Disabled Pre-schoolers [October 2018 (Revised Edition)]. Updated forms in word format for all the six subsystems can also be downloaded from the SWD website ([https://www.swd.gov.hk/en/index/site\\_pubsvc/page\\_rehab/sub\\_bookshelf/#4](https://www.swd.gov.hk/en/index/site_pubsvc/page_rehab/sub_bookshelf/#4)) or the Online Submission platform (<https://www.online-submission.swd.gov.hk>) for use.

2.6 The referrer can then make the application to CRSRehab by the relevant subsystem *Form 1*. CRSRehab will process the new application in 14 working days after receiving the completed application form. After registering the application, CRSRehab will return the original *Form 1* together with the confirmation of registration (*Form 1A*, *Form 1B* and/or *Notification of Assessment Result*) to the referrer. **The referrer should then verify the information recorded in these forms, and raise amendment, if any, to CRSRehab.** The referrer should pass the cleared *Form 1B* and/or *Notification of Assessment Result* to the applicant/family member(s)/carer(s)/guardian immediately for reference. For CRSRehab-MPH applications, after explanation by the referrer, the applicant/family member(s)/carer(s)/guardian should acknowledge receipt of the *Form 1B* by signing at the back with a copy retained by the referrer on file for record purpose. Whenever there is any change of information including change of type of placement concerning the application, the referrer should inform CRSRehab by the data updating form (*Form 3*) and CRSRehab will reply to the referrer with a fresh *Form 1A* and *Form 1B* together with the original *Form 3*. For cases applying for transfer to the IWL under CRSRehab-MPH, *Form 4A* and *Annex to Form 4A* “Letter to applicants applying for transfer to the Inactive Waiting List” would be issued by CRSRehab.

2.7 In making the application, please take note of the following remarks for CRSRehab-MPH, CRSRehab-ExMI, CRSRehab-SGHMMHC and CRSRehab-SE:

**CRSRehab-MPH** On admission to single hostel services, i.e. supported hostel and single hostel for mentally/physically handicapped, applicants should have already been engaged or arranged to be engaged in day programmes such as open employment, supported employment (SE), sheltered workshop (SW) or other day activities, etc. to ensure that they will not be left unoccupied in the day time while residing in the hostel.

**CRSRehab-ExMI** At the stage of admission, no commitment on day programme is required for halfway house referrals whereas day programme engagement is required for supported hostel referrals. Long stay care home applicant will forfeit his/her placement in SW or SE and the referrer should submit *Form 3* to respective subsystem to withdraw the day service waitlisting once admission is completed.

**CRSRehab-SGHMMHC** On admission to Small Group Home for Mildly Mentally Handicapped Children/Integrated Small Group Home, applicants are usually attending special schools or training in other institutions.

**CRSRehab-SE** Wherever possible, an applicant assessed to have the potential for SE should be encouraged to try the service. Nevertheless, if an applicant of SE is eventually assessed to be not suitable for SE service or discharged from a SE unit in less than 3 months, the referrer may, subject to justifications provided by the referrer and the rehabilitation unit, request CRSRehab-MPH/CRSRehab-ExMI to retain the original date of application for placement of SW.

### **Location Preference**

2.8 Placement will normally be offered according to the preferences of the applicant as indicated in the relevant *Form 1*. Applicants/family member(s)/carer(s)/ guardian are allowed to choose preferences by **region, district, individual rehabilitation unit, or a combination of them**. For details of the number and types of the preferences for respective rehabilitation services with waiting lists, please refer to Appendix 1. However, preference for a particular rehabilitation unit without valid grounds is not encouraged for it will delay the applicant in receiving rehabilitation service. The order of location preferences is of **equal weight** in the chance of being selected from the waiting list.

### **Updating of Case Information**

2.9 A referrer is required to update the applicant's changes that will affect the placement requested, such as personal particulars (e.g. name, residential district or address), type of disabilities, day placement required, location preference, referrer, preference for transfer to the IWL under CRSRehab-MPH and vice versa, etc. via *Form 3*. If the applicant with mental and/or physical handicap requests to change day placement to day cum residential placement, the referrer has to submit CRSRehab-MPH *Form 1*. If the applicant with mental and/or physical handicap requests to change residential placement to day cum residential placement, the referrer has to submit CRSRehab-MPH *Form 3*.

## **Change of Service/Addition of Service**

2.10 The referrer should notify CRSRehab via relevant subsystem *Form 3* if the applicant is assessed to be in need of other types of service. The referrer may have to submit additional documents as specified in para 2.4 if the applicant has to apply for the specific types of services under CRSRehab-MPH. The original application date will be retained for CRSRehab-MPH only. For CRSRehab-SGHMMHC, the application date will be retained (with the earliest retrospective date when the applicant reaches the age of fifteen) should the applicant switch to apply for Supported Hostel under CRSRehab-MPH. For CRSRehab-ExMI, new application date will be allotted for change type of service.

2.11 For applicant who is on waiting list of residential care service (RCS) at Long Term Care Services Delivery System (LDS) but wishes to apply for Care and Attention Home for the Aged Blind, the referrer shall make a fresh application to CRSRehab-AB. Upon confirming applicants' eligibility for the service, the referrer has to close the application for RCS at LDS and report to CRSRehab-AB for activating the application. If dating back the application to the LTC date of RCS of the applicant at LDS is required, the referrer shall apply to CRSRehab-AB for consideration on individual case's merit.

## **Transfer of Application from Waiting List of Residential Rehabilitation Service to Inactive Waiting List and Vice Versa under CRSRehab-MPH**

2.12 To better utilise the public resources and avoid premature admission to residential rehabilitation service, applicants waitlisting for residential care services under CRSRehab-MPH are allowed to opt for deferment of allocation of placement by transferring to the Inactive Waiting List (IWL) with the original application date retained. No residential service placement will be allocated as long as the applicant is on the IWL. Applicants may, through the referrer, apply to return to the Active Waiting List (AWL) with the original application date when necessary. Each applicant is allowed to opt to the IWL **once** only, unless with strong justification as assessed by referrer and approved by SWD on individual case's merit.

2.13 For applicant who wishes to apply for transfer to IWL, the referrer should notify CRSRehab-MPH via *Form 3* to transfer the applicant to the IWL with his/her original application date retained. Upon receipt of the notification, CRSRehab-MPH *Form 4A*, together with *Annex to Form 4A* to the applicant, will be issued to confirm the referrer about transfer of the applicant to IWL. The referrer should pass the letter to the applicant for information and retention.



2.14 For applicant who is offered a residential/paired day and residential rehabilitation service placement but prefers to maintain living in the community with support of his/her family members and/or community support services for the time being, the applicant/family member(s)/carer(s)/guardian may opt to transfer the application to the IWL. The referrer should notify CRSRehab-MPH via Form 7 to transfer the applicant to the IWL with his/her original application date retained. Upon receipt of the notification, CRSRehab-MPH will cancel the placement allocation, and then issue CRSRehab-MPH *Form 4A* together with *Annex to Form 4A* to the applicant to notify the referrer about transfer of the applicant to IWL. The referrer should pass the letter to the applicant for information and retention. For details, please refer to Appendix 6. For applicant who would like to be allocated day rehabilitation services first but to retain his/her paired day and residential application in the IWL, the referrer should submit CRSRehab-MPH *Form 3* together with the document(s) as specified in para 2.4. However, for applicant applying for paired day and residential rehabilitation services involving SW / IVRSC and supported hostel (SHOS), the referrer should submit CRSRehab-MPH *Form 1* to make a fresh application for day placement.

2.15 For applicant being hospitalised upon offer of residential rehabilitation services, he/she will be allowed to be transferred to the IWL no matter whether he/she has ever been transferred to the IWL before. For details, please refer to para. 2.26 to 2.27.

2.16 The referrer is required to review the cases on the IWL annually to ensure if the applicant would like to remain on the IWL, or to reactivate his/her application for residential rehabilitation service under CRSRehab-MPH. For applicant who would like to remain on the IWL, the referrer should submit *Form 3* to CRSRehab-MPH. For applicant who would like to reactivate his/her application for residential rehabilitation service under CRSRehab-MPH, the referrer should notify CRSRehab-MPH via CRSRehab-MPH *Form 3* together with an updated CRSRehab-MPH *Form 1* (standardised assessment) for applicant with changes in his/her health condition, or together with a CRSRehab-MPH *Form 1D* (assessment on the family coping condition) for applicants with no change on his/her health condition. Please refer to Appendix 7 for details.

2.17 Upon confirming applicant's need for residential rehabilitation service under CRSRehab-MPH, the applicant will be put back to the AWL. CRSRehab-MPH will then issue *Form 1A*, *Form 1B* and *Notification of Assessment Result* to the referrer. Placement will be offered according to the original date of application and applicant's placement choice as ascertained by the updated assessment when his/her turn arrives. Please refer to Appendix 8 for details.

## **Change of Application from CRSRehab residential service to Infirmery and Backdating Arrangement**

2.18 The referrer should review the type of rehabilitation service suitable for the case regularly. For a case on the waiting list of CRSRehab residential service and whose health condition has deteriorated to require the level of care in an infirmery, the referrer should refer the case to the Hospital Authority (HA) (Central Infirmery Waiting List Office for General Infirmery Service and Central Waiting List for Severe Mental Handicap Infirmery and Rehabilitation Services) for assessment. Once the case is confirmed to be suitable for infirmery service, the referrer should notify CRSRehab to close the case via *Form 3* and pass *Form 1A* and *Form 4* to respective office of HA for backdating the application for infirmery service to that of CRSRehab residential service.

2.19 If a case is rejected admission to a CRSRehab residential placement with the reason that the case is considered in need of infirmery care during the intake process, the referrer should immediately refer the case to HA for arranging an early assessment on the suitability for infirmery service. During the interim period, the case will be put back on the waiting list of CRSRehab-MPH, CRSRehab-ExMI, CRSRehab-AB and CRSRehab-SGHMMHC as appropriate for another matching. The referrer should notify CRSRehab of the assessment result of HA via *Form 3*. If the case is confirmed to be suitable for infirmery service, the referrer should follow the same procedures as mentioned in para. 2.18 above.

2.20 The details of the aforementioned procedures are described at the flow chart at Appendix 4 and a referral form to HA at Appendix 5. As there has been an agreement reached with HA to mutually recognise the application dates for cases initially applying CRSRehab residential service and later change to infirmery service and vice versa, there should not be applications both for CRSRehab residential service and infirmery service at the same time. At regular intervals, CRSRehab and HA would conduct data checking to reject such cases waiting for both services. For those cases that are found to have double applications, the referrers would be requested to re-examine the actual service need of their clients within one month. Otherwise, the case would be removed from the waiting list of CRSRehab.

- 2.21 List of recognised CRSRehab residential services for backdating from HA
- a. Residential Special Child Care Centre
  - b. Small Group Home for Mildly Mentally Handicapped Children / Integrated Small Group Home
  - c. Hostel for Severely Mentally Handicapped Persons
  - d. Hostel for Moderately Mentally Handicapped Persons
  - e. Hostel for Severely Physically Handicapped Persons
  - f. Hostel for Severely Physically Handicapped Persons with Mental Handicap
  - g. Care and Attention Home for Severely Disabled Persons
  - h. Care and Attention Home for the Aged Blind
  - i. Supported Hostel
  - j. Halfway House
  - k. Long Stay Care Home
  - l. Bought Place Scheme (BPS) for Private Residential Care Homes for Persons with Disabilities

## **Offer of Placement**

2.22 When an applicant declines a placement offer, his/her application will be deleted from the waiting list, except under the following circumstances:

- a. the placement offered does not match the applicant's service request or location preferences;
- b. the applicant (except those applying for residential or paired-up day and residential rehabilitation services under CRSRehab-MPH) is temporarily hospitalised (please refer to para. 2.26 to 2.27 for details);
- c. the applicant is assessed by relevant professionals to be in need of alternative rehabilitation service with supporting document(s);
- d. the applicant declines a single day placement while awaiting a paired-up day and residential placement;
- e. the applicant declines a BPS placement while awaiting for a subvented residential placement;
- f. the applicant has been approved to be temporarily frozen in the waiting list because of Continuation of Study and/or Extension of Years of Study in Aided Special Schools (please refer to para. 3.1 to 3.3 for details); or
- g. the applicant applying for residential or paired-up day and residential rehabilitation services under CRSRehab-MPH requests to be transferred to the IWL (please refer to para. 2.12 to 2.17 for details).

## **Placement out of Applicant's Preference**

***CRSRehab-MPH*** In order to enable the applicants to receive rehabilitation training as soon as possible, those waiting for paired-up day and residential services may be offered a single day placement in the first instance. Such offer only partially meets the need of their required service. No matter whether the applicants accept or decline the offer, their turn for paired-up day and residential services will not be affected.

## **Case Processing by the Referrer Upon Selection for Placement**

2.23 When an applicant is selected for admission, CRSRehab will notify the referrer by *Form 6* and a "*Notification of Case Selection to Rehabilitation Unit*" (*Form 6A*) will also be sent to the rehabilitation unit concerned in order to facilitate early communication among referrers, applicants and rehabilitation units for case intake.

***CRSRehab-AB and CRSRehab-SGHMMHC*** Upon receiving the "*Selection for Placement*" (*CRSRehab-AB Form 6*), a referrer should inform CRSRehab whether the applicant accepts the placement or not via *Form 7* within **3 weeks**. The referrer should also attach relevant documents as specified in *Form 6* to CRSRehab for applicant who accepts the placement offer.

**CRSRehab-MPH** Upon receiving the “*Selection for Placement*” (CRSRehab-MPH *Form 6*), the referrer should inform CRSRehab whether the applicant accepts the placement or not via *Form 7* within **3 weeks**. For applicant who accepts the placement offer, the referrer should also attach relevant documents as specified in *Form 6* to CRSRehab and a standardised medical examination form for CRSRehab-MPH directly to the rehabilitation unit concerned. For applicant who declines the placement offer of residential or paired-up day and residential rehabilitation services, the referrer should explore if he/she would like to be transferred to the IWL. If affirmative, the referrer should inform CRSRehab-MPH via *Form 7*. The applicant/family member(s)/ carer(s)/guardian should note that the applicant would not be selected for offer of residential or paired-up day and residential rehabilitation placement as long as he/she is on IWL. For cases opt to be transferred to the IWL upon offer of placement, please refer to para. 2.14 to 2.15 and Appendix 6 for details.

**CRSRehab-ExMI** Upon receiving the “*Selection for Placement*” (CRSRehab-ExMI *Form 6*), a referrer should inform CRSRehab whether the applicant accepts the placement or not via *Form 7* within **2 weeks**. Unlike the procedures of other CRSRehab subsystems, the referrer should send all relevant documents as specified in *Form 6* to the rehabilitation unit concerned in parallel when he/she replies to CRSRehab with the acceptance of the placement offer.

**CRSRehab-SE** Upon receiving the “*Selection for Placement*” (CRSRehab-SE *Form 6*), a referrer should inform CRSRehab whether the applicant accepts the placement or not via *Form 7* within **3 weeks**. Unlike the procedures of other CRSRehab subsystems, the referrer should send all relevant documents as specified in *Form 6* to the rehabilitation unit concerned when he/she replies to CRSRehab with the acceptance of the placement offer.

## Essential Documents for Processing of Applications

2.24 Essential documents specifically required by each subsystem for processing of the applications are as follows:

Subsystem	Essential Document	Validation Period
CRSRehab-MPH	<ul style="list-style-type: none"> <li>Clinical psychologist / Educational psychologist's report with indication on Intellectual Disability and assessment conducted on or above six years old (for the applicant to be intellectually disabled)</li> <li>Medical Report with indication on the applicant's physical disability, diagnosis and mobility level (for the applicant to be physically disabled).</li> <li>Medical Examination Form (MEF) (to be submitted to the rehabilitation unit concerned directly)</li> <li>For additional documents required for specific types of services, please refer to para 2.4.</li> </ul>	<ul style="list-style-type: none"> <li>Please refer to Appendix 3.</li> <li>MEF is valid for 6 months from the date of issue.</li> </ul>
CRSRehab-ExMI	<ul style="list-style-type: none"> <li>Psychiatric report</li> <li>Chest X-ray report /other medical/laboratory test report and other medical reports</li> </ul>	<ul style="list-style-type: none"> <li>Valid for 3 months from the date of issue.</li> <li>Valid for 12 months from the date of issue.</li> </ul>
CRSRehab-AB	<ul style="list-style-type: none"> <li>Certification on blindness</li> <li>CRSRehab-AB Form 2</li> </ul>	The period is either permanent or as stated in the certificate.
CRSRehab-SGHMMHC	<ul style="list-style-type: none"> <li>Clinical psychologist's report with indication on IQ Score.</li> </ul>	<ul style="list-style-type: none"> <li>Please refer to Appendix 3.</li> </ul>
CRSRehab-SE	<ul style="list-style-type: none"> <li>Clinical psychologist's report with indication on IQ Score</li> <li>Medical/Psychiatric report</li> <li>Medical Practitioner's report with certification on Hearing/Visual Impairment, Visceral Disability and Physical Handicap</li> </ul>	<ul style="list-style-type: none"> <li>Please refer to Appendix 3.</li> <li>Valid for 1 year from the date of issue.</li> <li>The period is either permanent or as stated in the report.</li> </ul>

Referrers should make sure that these documents are available and valid for submission by the time of application. Additional requirements for documents other than the above will be indicated in the relevant subsystem *Form 6*.

## Reminder to Referrers

2.25 When a referrer cannot make a reply upon case selection within the time frame designated by CRSRehab, CRSRehab will issue a reminder with a copy to the concerned Assistant District Social Welfare Officers for SWD units or agency heads for NGOs. If the reminder(s) is/are still unanswered or without final decision on the placement offered within the specific time frame, case will be closed automatically. The time frame for different subsystems is shown below:

Subsystem	Processing time for referrer/Action by CRSRehab				
CRSRehab-MPH	3 weeks	<i>1<sup>st</sup> reminder</i>	2 weeks		<i>Case closed</i>
CRSRehab-SE	3 weeks		2 weeks		
CRSRehab-AB	3 weeks		2 weeks		
CRSRehab-SGHMMHHC	3 weeks		2 weeks		
CRSRehab-ExMI	2 weeks		1 week	<i>2<sup>nd</sup> reminder</i>	

## Hospitalisation of Case

2.26 When an offer (except residential or paired-up day and residential rehabilitation placement under CRSRehab-MPH) is given but the applicant has been admitted into hospital, the referrer should notify CRSRehab by *Form 7* and the application will become non-active for 3 months and the referrer would be notified by *Form 4*. If the applicant could be discharged from hospital and ready for placement in rehabilitation service within **3 months since the admission to hospital**, the referrer can inform CRSRehab via *Form 3* and CRSRehab will re-activate the application with the original application date retained. It can be extended for **another 3 months** (i.e. a total of 6 months) only when there are valid grounds that the applicant can be discharged from hospital within the time frame and by that time the applicant can still fulfill the admission criteria of the service requested. Or else, the original offer will NOT be retained. The next offer will be provided according to the applicant's location preference. If CRSRehab does not receive any request for re-activating the application within the designated period, the application will be automatically deleted from the waiting list. Should the applicant still require rehabilitation services upon reassessment of his/her service needs when he/she is ready for discharge from hospital, a fresh application is needed.

**CRSRehab-ExMI** Applicants who are admitted to psychiatric hospital or psychiatric ward of general hospital will have their applications removed from the waiting list. Re-assessment of service need is required. For those applicants admitted to general hospital for treatment other than psychiatric treatment, the procedure will follow that of para. 2.26 above.

2.27 When an offer of residential or paired-up day and residential rehabilitation placement under CRSRehab-MPH is given but the applicant has been admitted into hospital and is unlikely to be discharged shortly, the referrer should notify CRSRehab-MPH by *Form 7*. The placement allocation will be cancelled and the applicant will be transferred to the IWL temporarily. CRSRehab-MPH will issue *Form 4A* to the referrer to confirm that the date of application will be retained. Upon discharge of the applicant from hospital and the applicant is ready for admission to residential rehabilitation services, the referrer should conduct reassessment on his/her service needs. If the applicant is still in need of residential rehabilitation services but his/her health condition has been changed, the referrer should submit both *Form 3* and *Form 1* (standardised assessment) to CRSRehab-MPH to update his/her service needs. If there is no change in the applicant's health condition and he/she is in need of the same service as registered, the referrer should submit both *Form 3* and *Form 1D* (assessment on family coping condition) to CRSRehab-MPH to reactivate his/her application. If CRSRehab-MPH does not receive any request for re-activating the application, the applicant will remain on the IWL and no residential placement will be offered. For details, please refer to Appendix 6 and Appendix 7.

### **Request for Non-activation**

2.28 Except the condition stipulated in para. 2.26-2.27 and para. 3.1-3.3, request for non-activation or suspension will not be accepted. Applicants who have no immediate need of service should apply at a later stage.

### **Case Deletion/Re-application**

2.29 The referrer should notify CRSRehab via relevant subsystem CRSRehab *Form 3* for deletion from the waiting list when an applicant is not in need of service. Upon receipt of the notification, CRSRehab will issue a CRSRehab *Form 4* to confirm the closure of the case. In case the applicant is subsequently in need of rehabilitation service again, the referrer should submit a fresh CRSRehab *Form 1* to apply for service again.

### **Report of Vacancy**

2.30 Rehabilitation units should inform CRSRehab any vacancy or anticipated vacancy via *Form 5* within **3 working days**. Upon receiving the notification of a vacancy, CRSRehab will arrange for case matching and a list of applicants selected via *Form 6A* will be sent to the rehabilitation units concerned subject to availability of referrals at hand. This practice is to encourage rehabilitation units and referrers to begin the intake process as soon as possible.



## Case Intake by Rehabilitation Units

2.31 Rehabilitation units should complete the intake process and admit the applicants within the designated time frame. Any rehabilitation unit that fails to do so will receive a reminder from CRSRehab with copies to the referrer and the agency head concerned. The time frame for different subsystems in CRSRehab is summarised below:

Subsystem	Processing time for Rehabilitation Unit/Action by CRSRehab					
CRSRehab-MPH	4 weeks	<i>1<sup>st</sup> reminder</i>	2 weeks	CRSRehab Office will check with the respective unit		
CRSRehab-SE	3 weeks		2 weeks			
CRSRehab-AB	4 weeks		2 weeks			
CRSRehab-SGHMMHC	4 weeks		2 weeks			
CRSRehab-ExMI	2 weeks		1 week	<i>2<sup>nd</sup> reminder</i>	1 week	CRSRehab Office will check with the respective unit

***CRSRehab-MPH, CRSRehab-AB and CRSRehab-SE*** The purpose of medical examination in CRSRehab-MPH, CRSRehab-AB and CRSRehab-SE is for formulating individual care plan rather than serving as a screening purpose. Pending medical examination should not be a reason for delaying admission of the applicant and flexibility should be applied whenever appropriate.

***CRSRehab-ExMI*** If the rehabilitation unit cannot complete the intake process within the designated time frame, i.e. 2 weeks, the case should be returned to CRSRehab for another placement. If justification (e.g. pending medical document, Chest X-ray report, etc.) can be provided, the rehabilitation unit should apply to CRSRehab for delaying admission.

2.32 For new rehabilitation units with bulk vacancies, the pace of admission should be kept in accordance with the schedule of phased admission as agreed with the Department.

## Rejection of Cases

2.33 An applicant who is rejected by a rehabilitation unit will be given another offer in accordance with the location preferences indicated by him/her. However, if the applicant has been rejected by two different agencies of the same type of service, the case would be closed and *Form 4* would be issued to referrer. The referrer is required to reassess the service need of the applicant. If the applicant is still in need of such service, the referrer should make fresh application to CRSRehab by *Form 1*. For applicants who indicate preference at one centre only, no second placement can be offered if he/she is rejected by that centre. However, the referrer may inform CRSRehab for updating the location preference by *Form 3* if the applicant wishes to be given a second offer.

***CRSRehab-MPH and CRSRehab-SE*** Cases having two records of rejection by different agencies of the same type of service (except the reason of no vacancy) will be taken out from the waiting list and the referrer will be requested to arrange for reassessment enlisting the input of concerned disciplines such as Medical Officer, Clinical Psychologist, Vocational Training Assessment Team, etc. as far as possible. After reassessment and upon the advice of the referrer, an applicant can be waitlisted for placement in the same service type or other types as appropriate and **the original application date will be retained.**

***CRSRehab-ExMI, CRSRehab-AB and CRSRehab-SGHMMHC*** Cases having two records of being rejected for the same service type by different agencies will be taken out from the waiting list and the referrer will be asked to arrange for reassessment. After reassessment and upon the advice of the referrer, an applicant can be waitlisted for placement of the same type or other types of service as appropriate as a **fresh** application with a **new application date**. If the case is in urgent need for placement, the referrer may consider applying for priority placement (please refer to para. 3.5).

## Cases Admitted into the Rehabilitation Units

2.34 Upon the applicant's admission to the required service, case will be closed in CRSRehab and be removed from the waiting list.

***CRSRehab-AB*** There will be times when applicant, who has been admitted into Care and Attention Home for the Aged Blind, is assessed to be in need of infirmary care and later transferred to the Infirmary Unit of the Home. The concerned Home should notify CRSRehab to update the case position via *Form 9*.

## **Removal from the Waiting List**

- 2.35 An applicant will be removed from the waiting list under the following circumstances:
- a. the applicant has been admitted to the required service;
  - b. the applicant requests withdrawal;
  - c. the applicant declines a placement offer of his/her indicated preference(s) without the approval of Continuation of Study/Extension of Years of Study, or has not applied to be transferred to the IWL under CRSRehab-MPH;
  - d. no application for re-activation before the end of the Continuation of Study/Extension of Years of Study, which is the date indicated in CRSRehab-MPH *Form 4* (please refer to para. 3.1 to 3.4 for details);
  - e. the referrer does not respond to CRSRehab even after reminder(s) are sent;
  - f. the applicant is rejected by two different agencies of the same type of service (according to para. 2.33, CRSRehab-MPH and CRSRehab-SE application date can be retained); or
  - g. the applicant has been hospitalised when a placement offer (except for residential or paired-up day and residential rehabilitation services under CRSRehab-MPH) is available (please refer to para. 2.26 to 2.27 for circumstances in which the applicant can be placed back to the waiting list).
- 2.36 Closed cases in need of rehabilitation service can make a fresh application by submitting *Form 1* through the referrer. The date of application of such cases will be counted anew.

### Retention of Original “Date of Application” at Central Referral System for Rehabilitation Service - Subsystem for the Mentally/Physically Handicapped (CRSRehab-MPH) for Students applying for “Continuation of Study” and “Extension of Years of Study” at Aided Special Schools

#### Continuation of Study (COS)

3.1 In view of the measures undertaken by the Education Bureau (EDB) in respect of extension of years of study for needy special school students, the SWD has put in place the following arrangement for the students applying for Continuation of Study (COS). Students who are approved for COS may decline a placement offer and apply for a retention of their original date of application when they are selected by CRSRehab-MPH for admission to adult rehabilitation services, viz, day training [i.e. Day Activity Centre (DAC), Sheltered Workshop (SW) and Integrated Vocational Rehabilitation Service Centre (IVRSC)] and various residential care services, during the COS :

- a. The referrer has to notify CRSRehab vide CRSRehab-MPH *Form 7* of the applicant’s request for COS and not accepting the offer.
- b. Upon notification, CRSRehab will reply the referrer vide CRSRehab-MPH *Form 4* (for day rehabilitation services) to confirm the approval of COS, or *Form 4A* (for residential or paired-up day and residential rehabilitation services) to confirm the transfer of the application to the IWL. The placement allocation will be cancelled and the application for all services under CRSRehab-MPH will be put aside with the original date of application retained.
- c. For applications of day rehabilitation services, the case will be removed from the waiting list temporarily. The referrer has to re-activate the application by **submitting *Form 1* (only required to fill in Sections I, II, VIII and IX) before the end of COS to retrieve the original application date, otherwise, the application will be removed from CRSRehab-MPH automatically.**
- d. For applications of residential or paired-up day and residential rehabilitation services, the applications will be transferred to the IWL. The referrer has to inform CRSRehab vide an updated CRSRehab-MPH *Form 1* (for cases in need of changing service type) / *Form 1D* (for cases continue to waitlist for the original services) and *Form 3* to re-activate the application for placement allocation. The case will then be put back to the AWL. If CRSRehab-MPH does not receive any request from the referrer for re-activating the application, it will remain on the IWL and no residential placement will be offered.

## **Extension of Years of Study (EoS) for Students of Aided Special School**

3.2 Students of aided special schools under the New Senior Secondary (NSS) academic structure will graduate from school upon completion of Secondary 6. The norm is that students with intellectual disability complete the primary and secondary education in 12 years, and students with normal intelligence pursuing ordinary curriculum in schools for children with physical disability and schools for children with hearing impairment complete the primary and secondary education in 13 years. Individual students may need to extend their years of study due to “valid reasons” and schools are provided with “pre-set quota” of additional places to address such needs. For details, please refer to the Circular on “Improvement Measures on Extension of Years of Study for Students of Aided Special Schools” and Guidelines for Special Schools on School-based Mechanism for Handling the Extension of Years of Study for Students on the website of EDB.

3.3 The SWD has put in place the arrangement as similar to COS as mentioned above for the students being granted the EoS to decline a placement offer and apply for a retention of their original date of application when they are selected by CRSRehab-MPH for admission to adult rehabilitation services during the EoS.

### **Re-activation of Application under CRSRehab**

3.4 The referrer is expected to conduct regular case review to ensure timely re-activation of application under CRSRehab. If CRSRehab does not receive any request for re-activation of the application before the end of the COS or EoS, the original date of application for day rehabilitation service will not be retained. A fresh application is needed if the applicant requires the service in the future. As for residential and paired-up day and residential rehabilitation services, the application will remain on the IWL and no placement will be offered to the applicant unless request for reactivation from the referrer is received. For applicants who would like to be allocated day rehabilitation services first but to retain their paired application in the IWL, the referrer has to submit CRSRehab-MPH *Form 3* together with the documents as specified in para. 2.4.

## Priority Placement

### 3.5 Purposes

Priority placement is a measure to meet urgent needs of applicant for services. Those approved for priority placement will be put on the top of the waiting list and accorded priority in allocation of service.

### 3.6 Criteria

- a. Priority placement will only be granted on an exceptional basis for applicant with strong justification(s) for urgent services. The referrer should consider individual situation case by case, including exploring the alternative services in the community and seek their supervisors' views when drawing up the recommendations for priority placement application.
- b. The following are some of the examples that may warrant urgent services:
  - I. The parents/carers are suffering from health/mental problem and are unable to continue assuming the caring role;
  - II. The applicant is facing moral/physical danger or abuse by family member(s) or carer(s);
  - III. The applicant is homeless and has no relatives/carers to look after him/ her;
  - IV. The applicant is a Ward of DSW/High Court; or
  - V. Other justified social and/or medical grounds, etc.

### 3.7 Application procedures

- a. The referrers are required to submit to CRSRehab a completed CRSRehab-*Form 10* for priority placement, with endorsement of:
  - I. Assistant District Social Welfare Officer/Senior Social Work Officer rank or above (for SWD service units);
  - II. Agency Head/service coordinator/designated representative (for NGO service units); or
  - III. Departmental Manager (for MSSD/HA)
  - IV. Principal of Special School
- b. For CRSRehab-MPH services, the referrers are also required to submit an updated CRSRehab-MPH *Form 1*.
- c. As the applicants applying for priority placement are in need of urgent services, any preference on service units or location will not be considered, except those with compelling grounds.
- d. If clarification or further information is required, CRSRehab will contact the referrer within two weeks upon receipt of the application.

- e. The referrer should justify the applicant's need and/or urgency for priority placement by requiring the applicant to submit relevant documentary proof, such as medical certificate, birth certificate/identity card, bank account, employment proof, statutory declaration, etc., for checking.
- f. CRSRehab may ask referrers to submit supporting document for checking and conduct further inspections, e.g. phone enquiry, interview, home visit, etc., if necessary.
- g. CRSRehab will take proper follow up actions on any revealed irregularities and cases of undue delay.

### 3.8 Approval of applications

- a. The application will be approved/disapproved by an officer of SSWO rank or above with support of an officer of SWO rank or above and recommendation by an officer of SWA rank or above.
- b. The result of the application will be given to the referrer via CRSRehab- *Form10A* within 4 weeks upon receipt of referrer's application and all relevant information/documentary proofs.
- c. Under normal circumstances, if the applicants decline the placement offer under priority placement, the names of the applicants will be removed from the waiting list immediately.

### 3.9 Review of applications

- a. The referrer should review the conditions of the applicant periodically or as needed. A renewed application has to be submitted to CRSRehab according to the set procedures at para. 3.7 should the reasons for priority placement be changed.
- b. When a priority placement is offered, the referrer has to confirm whether the reasons for priority placement as stated in the latest submission of CRSRehab-*Form 10* is still valid.
- c. Should the reasons for priority placement have subsided, the applicant could still waitlist for the placement on normal waiting list.
- d. Under normal circumstances, if the applicants decline the placement offered under priority placement, the names of the applicants will be removed from the waiting list immediately.

## **Case Swapping**

3.10 Case swapping is only allowed in CRSRehab-MPH and CRSRehab-SE:

***CRSRehab-MPH*** Two service users in different rehabilitation units of the same type of service may sometimes want to swap their places because of, say, the location of the rehabilitation units are so far away from home that their aged parents have difficulty in taking them out for home leave. Normally, swapping between agencies on the same type of service within the same district will not be allowed. The rehabilitation units concerned may write to CRSRehab for approval by giving the reason for the swapping together with the consent letters of the service users/family member(s)/carer(s)/guardian. If the case is considered justified, CRSRehab will issue a written reply to endorse the arrangement. Any swapping without formal approval from CRSRehab-MPH will not be recognised.

***CRSRehab-SE*** In view of the expertise of individual rehabilitation units in delivering particular SE models and serving clientele of special disabilities groups, case swapping/case transfer between two agencies operating SE is allowed if it is for the best interest of the service users involved. The concerned agencies should write to CRSRehab-SE for approval for the swapping/case transfer together with the consent letters of the service users/family member(s)/carer(s)/guardian. If the case is considered justified, CRSRehab-SE will issue a written reply to endorse the arrangement. Any swapping/case transfer without formal approval from CRSRehab-SE will not be recognised.

***CRSRehab-ExMI, CRSRehab-AB and CRSRehab-SGHMMHC*** Case swapping in these three subsystems are not allowed.

## **Appeal Against Decision Made by Rehabilitation Units**

3.11 It is the responsibility of the referrer to re-assess those cases being rejected by rehabilitation units. If the referrer finds the reason for rejection given by rehabilitation unit is not justified, he/she can inform CRSRehab by telephone in the first instance and then send an appeal letter to the concerned rehabilitation unit with a copy to the respective Social Work Officer (Rehabilitation & Medical Social Services) of CRSRehab. The Social Work Officer (Rehabilitation & Medical Social Services) should then liaise with the concerned rehabilitation unit to identify any operational difficulties it may have. During the interim period, CRSRehab will not select the case to another rehabilitation unit until the appeal is settled. If the rehabilitation unit insists on the original decision and the referrer disagrees to it, the case should be brought up to the District Social Welfare Officer overseeing the concerned rehabilitation unit for assistance.



## **Chapter IV Roles and Responsibilities**

---

### **Roles and Responsibilities of Referrers**

4.1 Within the context of the referral process in CRSRehab, a “Referrer” refers to any social worker/professional accepted by CRSRehab subsystems that makes an application to CRSRehab on behalf of his/her applicant for rehabilitation service.

4.2 The activities of referrers include:

- a. To assume the role of a case manager for the customer in respect of the referral for rehabilitation service, a referrer should identify and assess the applicant’s genuine need for rehabilitation services. In order to assess the applicant’s suitability for different types of placement, a referrer should consider enlisting assistance from the Medical Officer, the Clinical Psychologist or the Vocational Assessment Team, etc. so as to ensure that the service(s) referred for best suits the need of the applicant.
- b. To realise the objective of integrating people with disabilities into the community and to strengthen the concept of care in the family, the referrer should, wherever appropriate, encourage the applicant to make use of community resources including day training/vocational rehabilitation to meet the latter’s and the family’s needs. Should the problem encountered by the applicant is solely on transportation and mobility, appropriate transport service or arrangement for change of work, schools or training centres should be considered before resorting to residential rehabilitation services.
- c. If the applicant has need for rehabilitation services, a referrer has to explain clearly to the applicant/family member(s)/carer(s)/guardian of the criteria in the application for rehabilitation services via the “Notes of Application for Rehabilitation Services” (Appendix 2a/2b/2c), and thereafter make application via *Form 1* to CRSRehab for appropriate service.
- d. To carry out regular case review, especially for the applicant's family situation and any changes in the applicant's disabilities or functioning level that may affect the placement need of the applicant. For applicants waitlisting for residential or paired-up day and residential rehabilitation services under CRSRehab-MPH, the referrer may have to assess the readiness of the applicants for admission to residential rehabilitation services, and to apply for transferring him/her to the IWL or returning back to the AWL as appropriate. The referrer should immediately update any relevant information/changes to CRSRehab via *Form 3* together with appropriate CRSRehab Forms / supporting documents as required.
- e. To process the case within 3 weeks (2 weeks for CRSRehab-ExMI) upon selection for placement and prepare the applicant and the parents for intake by the rehabilitation unit.
- f. To accompany and assist the applicant/family member(s)/carer(s)/guardian in the intake process conducted by the rehabilitation unit so as to prepare them for admission to the rehabilitation programme.

- g. To reassess the applicant's service need upon the withdrawal of placement offer by the applicant.
- h. To re-examine the applicant's suitability for the placement offered upon rejection by the rehabilitation unit. If the reason for rejection is not justified, the referrer should consider initiating an appeal.
- i. To notify CRSRehab via *Form 3* if the case is transferred to another referrer.
- j. To pass relevant notices issued by CRSRehab to the applicant upon the latter's application, change of placement type, and removal from the waiting list.

### **Roles and Responsibilities of Rehabilitation Units**

4.3 "Rehabilitation unit" refers to any service unit providing rehabilitation services and receiving case referrals from CRSRehab. Its activities include:

- a. To assess the referral and arrange for the admission of the successful applicant within 4 weeks (2 weeks for CRSRehab-ExMI and 3 weeks for CRSRehab-SE) and to inform CRSRehab and the referrer of the intake result via *Form 9*.
- b. To reassess those rejected cases put up for appeal.
- c. To inform CRSRehab of the discharge of trainees/residents via *Form 9* (*Form 3* for CRSRehab-ExMI) and the vacancy situation via *Form 5*.
- d. To provide regular statistics to the SWD.

### **Roles and Responsibilities of CRSRehab**

4.4 Its activities include:

- a. To vet the applications and ascertain whether the information is complete and relevant in connection to the rehabilitation service being applied for.
- b. To arrange for case selection from the waiting list and notify referrers within 3 working days upon the notification of a vacancy from the rehabilitation unit.
- c. To ensure that each step in the referral process be completed within the designated time frame, and to issue reminders to those referrers and rehabilitation units that fail to respond within schedule with copies to their supervisory bodies.
- d. To produce relevant statistics on the waiting lists of various rehabilitation services in CRSRehab.

## **Role and Responsibilities of Social Work Officers (Rehabilitation & Medical Social Services)**

- 4.5 Their activities include:
- a. To monitor the rehabilitation units of their enrolment, utilisation and pace of case admission.
  - b. To liaise with the concerned rehabilitation unit and the referrer on appeal cases.

## **Roles and Responsibilities of Assistant District Social Welfare Officers / District Social Welfare Officers / Agency Heads**

- 4.6 Their activities include:
- a. To ensure the effective delivery of services by the referrers and rehabilitation units in meeting the specified time frame in processing the referrals, in particular, those referrals with reminders.
  - b. To examine and endorse those applications with genuine need for priority consideration to CRSRehab.
  - c. To examine and endorse those applications with genuine need for swapping placement within the same service.
  - d. To examine appeals against rejection for admission by rehabilitation units under their jurisdiction. (only applicable to District Social Welfare Officer and Assistant District Social Welfare Officer)

### **Services for the Mentally / Physically Handicapped**

Q1: Do I need to attach a psychological report to the application for services for the mentally handicapped?

A1: The applicant should be certified by a psychologist to be mentally handicapped when applying for the services for the mentally handicapped persons. Although there is no need to attach a copy of psychological report at the time of making application, the referrer is strongly advised to submit the psychological report, if available, to CRSRehab for record purpose. Upon acceptance of the placement offer, the referrer should have the psychological report with indication on the applicant's intellectual disability and the level of severity readily available and submit to CRSRehab for processing.

Q2: How can I know whether a psychological report is valid or not?

A2: Please refer to Appendix 3 for a detailed description on the validity of a psychological assessment report.

Q3: I find that the applicant's psychological report is no longer valid when he/she is selected for placement. What can I do?

A3: In case the psychological report is invalid upon selection for placement, it is worthwhile to conduct another psychological assessment, so that relevant information about the applicant's intellectual development as well as the functional level can be ascertained.

Q4: Is home leave a compulsory requirement for a placement in the rehabilitation units?

A4: Though home leave is encouraged for applicants who are receiving residential service, it is not a compulsory requirement for those admitted to rehabilitation units providing 7-day-per-week hostel service. Therefore, the frequency of home leave can be agreed among the applicant, referrer and rehabilitation unit on individual case situation.

Q5: Are applicants allowed to be transferred to the Inactive Waiting List (IWL) for once only?

A5: Applicants are allowed to opt in and opt out of IWL once, unless with strong justification as assessed by referrer and approved by SWD on individual case's merit. However, for those being hospitalised with uncertain date of discharge upon service matching, they will be allowed to be transferred to IWL no matter they have ever applied for transfer to IWL. For applicants opting out of IWL, they are supposed to be ready for acceptance of the placement(s) offered. Hence, applicants/family member(s)/carer(s)/guardian are advised to discuss with the referrer before returning to the AWL. Besides, they are advised to indicate the placement choice(s) clearly and specifically as appropriate so that applicants could be allocated with the services pertaining to their individual need.

Q6: Would there be any minimum/maximum time limit for the applicants to stay on the IWL?

A6: No. The applicant/family member(s)/carer(s)/guardian can apply for opt in and opt out of the IWL according to their own circumstances and needs. To ensure that the needs of the applicant/family member(s)/carer(s)/guardian could be identified timely, the referrer is required to conduct regular case review to explore if the applicant(s) would like to stay on the IWL continuously or return to the AWL. On the other hand, the applicant/family member(s)/carer(s)/guardian can also make direct request to the referrer for returning to the AWL.

Q7: Would the referrer need to conduct standardised assessment every time upon case review?

A7: No. The referrer only needs to explore the current condition of the applicant upon regular case review. Yet, if the applicant/family member(s)/carer(s)/guardian indicates his/her need to return to the AWL, the referrer has to assess and confirm if there is change in applicant's health condition. If affirmative, the referrer has to conduct standardised assessment again to confirm which type of services placement that the applicant is in need and submit *Form 1* together with Form 3 to CRSRehab-MPH. Otherwise, the referrer only needs to assess the family coping condition and submit *Form 1D* together with *Form 3* to CRSRehab-MPH.

### Services for the Ex-Mentally III

- Q1: If the chest X-ray report is not available while other documents are prepared, should the referrer send the available documents to the rehabilitation unit concerned and reply to CRSRehab-ExMI with a completed Form 6?
- A1: No, the referrer should confirm by Form 6 only when all documents are sent to the rehabilitation unit. It is agreed by the rehabilitation units that psychiatric report within 3 months and chest X-ray report/other medical/laboratory test report within 12 months are considered as valid documents.
- Q2: Should the referrer play an active role to contact rehabilitation units for arrangement of pre-admission interview?
- A2: When a case is selected from the waiting list, CRSRehab-ExMI will send the case information and the referrer's office telephone number to the rehabilitation unit. From this time point, the responsible worker of the rehabilitation unit should take initiative to contact the referrer while the referrer should prepare the reply to CRSRehab-ExMI through Part II of *Form 6* after sending all relevant documents to the rehabilitation unit.
- Q3: If the applicant has declined the day placement offer, will his/her application for residential placement be cancelled?
- A3: Situation 1: If the referrer informs CRSRehab-ExMI that the applicant has declined the day placement only, the latter's application for residential placement will still be valid.  
Situation 2: If the applicant has been admitted to psychiatric hospital or psychiatric ward of general hospital, the application for both day and residential placement will be voided.
- Q4: Can the applicant retain his/her original application date if he/she is in need of other type of service within the CRSRehab-ExMI subsystem?
- A4: No, the applicant cannot retain his/her original application date for change of other type of service within CRSRehab-ExMI subsystem. If the applicant is in urgent need of any type of placement, the referrer may consider applying for priority placement.

## **Services for the Aged Blind**

Q1: Can I waitlist a “suspected” blind aged client for Care and Attention Home for the Aged Blind if he/she is identified to be in need?

A1: No, you should obtain the certification on blindness from a Medical Officer of the Eye Department/Eye Clinic or a registered Ophthalmologist in private practice before waitlisting the client for the service under the subsystem CRSRehab-AB. You may waitlist appropriate service for the client under Long Term Care Services Delivery System (LDS) first while pending the certification and apply for dating back of application date according to the prevailing procedures as stated in para. 2.11 if required.

## **Services for Mildly Mentally Handicapped Children**

Q1: Do I need to attach a psychological report to the application for Small Group Home for Mildly Mentally Handicapped Children / Integrated Small Group Home?

A1: Yes, the referrer should attach a psychological report with indication on IQ score when applying for such service.

Q2: How can I know whether a psychological report is valid or not?

A2: Please refer to Appendix 3 for a detailed description on the validity of a psychological assessment report.

Q3: Can children with borderline intelligence, moderate/severe grade mental handicap waitlist for Small Group Home for Mildly Mentally Handicapped Children / Integrated Small Group Home?

A3: Small Group Home for Mildly Mentally Handicapped Children / Integrated Small Group Home is designed to cater for the needs of mildly mentally handicapped children with IQ score ranging from 50-70.

## **Supported Employment Service**

Q1: What is the “Fallback System” and its operational details?

A1: The Fallback System is set up to encourage clients of sheltered workshops (SWs) and waitlistees of SW to try supported employment (SE). Its operational details are as follows:

i. For Ex-sheltered Workers:-

Who are found unable to benefit from the SE service within 3 months of discharge from SW and who are assessed to require SW service again, they can be readmitted into their original SW immediately if a vacancy exists, otherwise at the first opportunity available.

ii. For existing applicants who are waitlisting for SW placement:-

To encourage suitable applicants to try SE service, their original application date could be retained for transferring back to the waiting list for SW, subject to justifications as provided by the referrer, if they are subsequently assessed by operators of SE units to be not suitable for SE service and are discharged from SE service unit in less than three months.

Applicants who have applied for a pair-up SW and residential placement may take up SE and attend a hostel for moderately mentally handicapped persons or supported hostel when a residential placement becomes available.



## Chapter VI CRSRehab Forms

### 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 prefix on the forms. An overview of the forms is as below:

Form No.	From	To	Name of the form	Applicable in CRSRehab				
				MPH	ExMI	AB	SGHMMC	SE
F.1	Ref	CRSRehab	Registration Form	✓	✓	✓	✓	✓
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.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	Letter to applicants applying for 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	✓	✓	✓	✓	✓
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.8A	RU	Ref	Reply to Applicant	×	×	×	×	×
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	✓	✓	✓	✓	✓
Related Document			Day/Residential Rehabilitation Service for Mentally or Physically Handicapped Persons - Medical Examination Form	✓	×	×	×	×
			Visual Examination Form for Admission to Care & Attention Home for the Ages Blind	×	×	✓	×	×

Ref: Referrer  
RU: Rehabilitation Unit

Updated forms in word format for all the 6 subsystems can be downloaded from the SWD website ([www.swd.gov.hk/en/index/site\\_pubsvc/page\\_rehab/sub\\_bookshelf/#4](http://www.swd.gov.hk/en/index/site_pubsvc/page_rehab/sub_bookshelf/#4)) or the Online Submission platform (<https://www.online-submission.swd.gov.hk>) for use

**【RESTRICTED】****Central Referral System for Rehabilitation Services – Subsystem for the Mentally/Physically Handicapped**  
**Application for Day<sup>Note 1</sup>/Residential Services<sup>Note 2</sup> and Standardised Assessment Tool for Residential Services for People with Disabilities****I. Personal Particulars**

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

**II. Disability**

1. Physical Disability	<input type="checkbox"/> Not physically disabled ( <i>please proceed to Item 2</i> ) <input type="checkbox"/> Quadriplegia <input type="checkbox"/> Paraplegia <input type="checkbox"/> Hemiplegia <input type="checkbox"/> Cerebral palsy <input type="checkbox"/> Loss of upper or lower limbs <input type="checkbox"/> Loss of hand/foot or finger/toe <input type="checkbox"/> Others, please specify:
2. Intellectual Disability	<input type="checkbox"/> Not intellectually disabled <input type="checkbox"/> Profound <input type="checkbox"/> Severe <input type="checkbox"/> Moderate <input type="checkbox"/> Mild Date of psychological assessment: (dd) (mm) (yyyy)
3. Other Disability (may choose more than one item)	<input type="checkbox"/> Speech impairment <input type="checkbox"/> Deaf / Hearing impairment <input type="checkbox"/> Visual impairment ( <input type="checkbox"/> Blind/ <input type="checkbox"/> Partially impaired) <input type="checkbox"/> Autism <input type="checkbox"/> Down Syndrome <input type="checkbox"/> Mental illness, please specify: <input type="checkbox"/> Other, please specify:
4. Illness/Health Problem	Please specify if any:
5. Mobility	<input type="checkbox"/> Walk unaided <input type="checkbox"/> Walk with escort <input type="checkbox"/> Walk with aid <input type="checkbox"/> Wheelchair bound <input type="checkbox"/> Bed ridden
6. Ability to Climb Stairs/Slope	<input type="checkbox"/> Capable to climb stairs/slope by self <input type="checkbox"/> Climb stairs/slope with other's assistance <input type="checkbox"/> Unable to climb stairs/slope even with other's assistance
7. Public Transport (Excluding Taxi)	<input type="checkbox"/> Manage without escort <input type="checkbox"/> Manage with escort <input type="checkbox"/> Cannot manage with escort
8. Assistive Devices Used	<input type="checkbox"/> Hearing aid <input type="checkbox"/> Wheelchair <input type="checkbox"/> Walking aids other than wheelchair <input type="checkbox"/> Prosthesis / artificial limb <input type="checkbox"/> Others:
9. Treatment Receiving	<input type="checkbox"/> Occupational therapy <input type="checkbox"/> Physiotherapy <input type="checkbox"/> Others:

**III. Nursing Care Need**

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 service. Assessor should conduct assessment for applicant requesting residential service, irrespective of the age of the carer.

Area of care	Care item	Score
1. <u>Skin Problem</u> 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. <u>Feeding Problem</u> During the past month:	4 Applicant is a severely/profoundly intellectually disabled person, and required tube feeding. 3 Applicant required thick and easy for the diet, and had frequent choking during feeding. 3 Applicant is not a severely/profoundly intellectually disabled person, 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. <u>Medication</u> 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. <u>Continence Control</u> During the past month:	3 Uncontrolled double incontinence. <sup>1</sup> 3 Applicant used indwelling urinary catheter or stoma and is a severely/profoundly intellectually disabled person. 2 Applicant used indwelling urinary catheter or stoma and is not a severely/profoundly intellectually disabled person. 1 Wetting/soiling of pants. 0 None of the above.	
5. <u>Epilepsy Condition</u> 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. <u>Oxygen Therapy</u> Requiring oxygen therapy for a total of 3 months during the past year:	4 Applicant is a severely/profoundly intellectually disabled person, and can perform daily activities after oxygen therapy. 4 Applicant cannot perform daily activities after oxygen therapy. <sup>2</sup> 3 Applicant is not a severely/profoundly intellectually disabled person, and can perform daily activities after oxygen therapy. 0 None of the above/Just using Positive Airway Pressure (PAP) Machine without oxygen therapy.	
7. <u>Suctioning</u> During the past month:	4 Required regular suction. 0 None of the above.	
8. <u>Bed Ridden</u> During the past month:	4 Bed ridden and totally dependent in care. 0 None of the above.	
9. <u>Special Nursing Care</u> During the past month:	4 Required Tracheostomy care. 3 Required Continuous Ambulatory Peritoneal Dialysis (CAPD). 0 None of the above.	
	The <b>highest</b> score of the above care items	

<sup>1</sup> "Double incontinence" refers to unable to control bladder and bowel.

<sup>2</sup> "Applicant cannot perform daily activities" refers to applicant develop shortness of breath even with a minor movement.

#### IV. Functional Impairment<sup>3</sup>

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 6.1 or 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:

<sup>3</sup> 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): <table style="display: inline-table; vertical-align: middle; margin-left: 10px;"> <tr> <td><input type="checkbox"/></td> <td style="padding-left: 5px;">inappropriate sexual behavior</td> </tr> <tr> <td><input type="checkbox"/></td> <td style="padding-left: 5px;">offensive behavior</td> </tr> <tr> <td><input type="checkbox"/></td> <td style="padding-left: 5px;">repetitive behavior</td> </tr> </table>	<input type="checkbox"/>	inappropriate sexual behavior	<input type="checkbox"/>	offensive behavior	<input type="checkbox"/>	repetitive behavior	
<input type="checkbox"/>	inappropriate sexual behavior							
<input type="checkbox"/>	offensive behavior							
<input type="checkbox"/>	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 physically/intellectually disabled person or has severe mental illness
(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 disabled or chronically ill persons 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 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)	<input type="checkbox"/>
	Moderate nursing care need	<input type="checkbox"/>
	High nursing care need	<input type="checkbox"/>
	Very high nursing care need	<input type="checkbox"/>
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)	<input type="checkbox"/>
	Low functional impairment	<input type="checkbox"/>
	Moderate functional impairment	<input type="checkbox"/>
	High functional impairment	<input type="checkbox"/>
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)	<input type="checkbox"/>
	Has challenging behaviour but does not need rehabilitation service with more staff	<input type="checkbox"/>
	Has challenging behaviour and needs rehabilitation service with more staff	<input type="checkbox"/>
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	<input type="checkbox"/>
	There is serious problem in the applicant’s interpersonal relationship	<input type="checkbox"/>
	There is considerable risk in applicant’s safety	<input type="checkbox"/>
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 services at present. (The applicant can re-apply and be assessed again in the future whenever necessary.)	<input type="checkbox"/>
	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 service.	<input type="checkbox"/>
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), On the Job Training Programme for People with Disabilities and Day Activity Centre (DAC)	<input type="checkbox"/>
	Community Residential 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)	<input type="checkbox"/>
	Hostel for Moderately Mentally Handicapped Persons (HMMH)	<input type="checkbox"/>
	Hostel for Severely Mentally Handicapped Persons (HSMH)	<input type="checkbox"/>
	Hostel for Severely Physically Handicapped Persons (HSPH)	<input type="checkbox"/>
	Care and Attention Home for Severely Disabled Persons (C&A/SD)	<input type="checkbox"/>
	Infirmity Service (referrer would make direct application to the Hospital Authority)	<input type="checkbox"/>
3. In case there is situation that is not covered in the above assessment and warrants the need for residential 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 service/reason(s) warranting the need for residential 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 community support service, community residential service or infirmary service is recommended, please proceed to Section IX and make application to the agency concerned direct.)

<p><u>Day Training</u> (referrer should complete Section I and II before completing this part)</p>	<input type="checkbox"/> Sheltered Workshop/Integrated Vocational Rehabilitation Services Centre (for Intellectually Disabled Persons) [SW/IVRSC (MH)] <input type="checkbox"/> Sheltered Workshop/Integrated Vocational Rehabilitation Services Centre (for Physically Disabled Persons) [SW/IVRSC (PH)] <input type="checkbox"/> Sheltered Workshop/Integrated Vocational Rehabilitation Services Centre (for Visually Impaired Persons) [SW/IVRSC (VI)] <input type="checkbox"/> Day Activity Centre (for Intellectually Disabled Persons) [DAC (MH)] <input type="checkbox"/> Others, please specify:
<p><u>Residential Services/Day and Residential Services</u> (referrer should complete Section I to VII and confirm that applicant has residential need before completing this part)</p>	<input type="checkbox"/> Supported Hostel (for Intellectually Disabled Persons) [SHOS(MH)] <input type="checkbox"/> Supported Hostel (for Intellectually Disabled and Visually Impaired Persons) [SHOS(MH+VI)] <input type="checkbox"/> Supported Hostel (for Physically Disabled Persons) [SHOS(PH)] <input type="checkbox"/> Hostel for Severely Physically Handicapped Persons (HSPH) <input type="checkbox"/> Hostel for Moderately Mentally Handicapped Persons (HMMH) <input type="checkbox"/> Sheltered Workshop/Integrated Vocational Rehabilitation Services Centre and Hostel for Moderately Mentally Handicapped Persons (SW/IVRSC and HMMH) <input type="checkbox"/> Sheltered Workshop/Integrated Vocational Rehabilitation Services Centre and Hostel for Severely Physically Handicapped Persons (SW/IVRSC and HSPH) <input type="checkbox"/> Day Activity Centre and Hostel for Severely Mentally Handicapped Persons [DAC & H (MH)] <input type="checkbox"/> Care and Attention Home for Severely Disabled Persons (for Intellectually or Physically Disabled Persons) (C&A/SD) <input type="checkbox"/> Others, please specify:
<p><u>BPS Option <sup>Note 1</sup> for Residential Services/Day and Residential Services above</u></p>	<input type="checkbox"/> 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 service?  Yes  No

3. Location Preference

Day Placement	Residential Placement
<input type="checkbox"/> Applicant has no Location Preference  <input type="checkbox"/> Applicant would have the following location preference and understand that the waiting time of receiving the related services would be longer:  1. _____ 2. _____ 3. _____	<input type="checkbox"/> Applicant has no location preference and would receive residential services as soon as possible <input type="checkbox"/> Applicant would have the following location preference and understand that the waiting time of receiving the related services would be longer:  1. _____ 2. _____ 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 1 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—弱智／肢體傷殘人士子系統  
日間訓練<sup>註一</sup>／住宿服務<sup>註二</sup>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	<input type="checkbox"/> 男 <input type="checkbox"/> 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： <input type="checkbox"/> 中西區 <input type="checkbox"/> 灣仔 <input type="checkbox"/> 東區 <input type="checkbox"/> 南區 <input type="checkbox"/> 離島 九龍： <input type="checkbox"/> 觀塘 <input type="checkbox"/> 黃大仙 <input type="checkbox"/> 九龍城 <input type="checkbox"/> 旺角 <input type="checkbox"/> 油麻地 <input type="checkbox"/> 深水埗 <input type="checkbox"/> 將軍澳 <input type="checkbox"/> 西貢 新界： <input type="checkbox"/> 上水及粉嶺 <input type="checkbox"/> 馬鞍山 <input type="checkbox"/> 沙田 <input type="checkbox"/> 大埔 <input type="checkbox"/> 元朗 <input type="checkbox"/> 屯門 <input type="checkbox"/> 天水圍 <input type="checkbox"/> 荃灣 <input type="checkbox"/> 葵涌及青衣
6. 現正接受的服務 (可選擇多項)	<input type="checkbox"/> 無 <input type="checkbox"/> 特殊學校 <input type="checkbox"/> 特殊學校寄宿服務 社區支援服務： <input type="checkbox"/> 地區支援中心 <input type="checkbox"/> 暫託住宿服務 <input type="checkbox"/> 綜合家居照顧服務 <input type="checkbox"/> 其他，請註明： 日間訓練服務： <input type="checkbox"/> 綜合職業康復服務中心 <input type="checkbox"/> 輔助就業 <input type="checkbox"/> 庇護工場 <input type="checkbox"/> 殘疾人士在職培訓計劃 <input type="checkbox"/> 展能中心 住宿服務： <input type="checkbox"/> 私營院舍 <input type="checkbox"/> 自負盈虧殘疾人士院舍 <input type="checkbox"/> 輔助宿舍 <input type="checkbox"/> 中度弱智人士宿舍 <input type="checkbox"/> 嚴重弱智人士宿舍 <input type="checkbox"/> 嚴重肢體傷殘人士宿舍 <input type="checkbox"/> 嚴重殘疾人士護理院 醫療服務： <input type="checkbox"/> 精神科住院服務 <input type="checkbox"/> 非精神科住院服務 <input type="checkbox"/> 日間醫院服務 <input type="checkbox"/> 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	<input type="checkbox"/> 並非肢體傷殘(請轉答第2項) <input type="checkbox"/> 四肢癱瘓 <input type="checkbox"/> 下肢癱瘓 <input type="checkbox"/> 左／右半身不遂 <input type="checkbox"/> 大腦癱瘓 <input type="checkbox"/> 缺失上或下肢 <input type="checkbox"/> 缺失手／腳掌或手／腳趾 <input type="checkbox"/> 其他，請註明：
2. 智障	<input type="checkbox"/> 並非智障 <input type="checkbox"/> 極度嚴重 <input type="checkbox"/> 嚴重 <input type="checkbox"/> 中度 <input type="checkbox"/> 輕度 心理評估日期： 年 月 日
3. 其他殘疾 (可選擇多項)	<input type="checkbox"/> 言語障礙 <input type="checkbox"/> 聽覺受損／弱聽 <input type="checkbox"/> 視覺受損( <input type="checkbox"/> 失明/ <input type="checkbox"/> 弱視) <input type="checkbox"/> 自閉症 <input type="checkbox"/> 精神病，請註明： <input type="checkbox"/> 唐氏綜合症 <input type="checkbox"/> 其他，請註明：
4. 疾病／健康問題	若有，請註明：
5. 活動能力	<input type="checkbox"/> 自行走動 <input type="checkbox"/> 需要他人攙扶走動 <input type="checkbox"/> 以復康用具輔助走動 <input type="checkbox"/> 需用輪椅 <input type="checkbox"/> 需臥床
6. 上樓梯或斜坡的能力	<input type="checkbox"/> 能自行上樓梯或斜坡 <input type="checkbox"/> 需要其他人協助上樓梯或斜坡 <input type="checkbox"/> 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)	<input type="checkbox"/> 可自行乘搭公共交通工具 <input type="checkbox"/> 需要他人陪同乘搭公共交通工具 <input type="checkbox"/> 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	<input type="checkbox"/> 助聽器 <input type="checkbox"/> 輪椅 <input type="checkbox"/> 輪椅以外的助行器具 <input type="checkbox"/> 義肢 <input type="checkbox"/> 其他：
9. 現正接受的治療	<input type="checkbox"/> 職業治療 <input type="checkbox"/> 物理治療 <input type="checkbox"/> 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 <sup>1</sup> 。 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 <sup>2</sup> 。 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 <b>最高</b> 分數		

<sup>1</sup> 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。

<sup>2</sup> 無法處理日常作息指小量活動便引致氣促。

#### IV. 功能缺損<sup>3</sup>

##### 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衛生要求（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
<p>1. 洗澡及洗頭</p> <p>1.1 洗澡（進行淋浴或坐浴）.....（ ）</p> <p>1.2 洗頭.....（ ）</p> <p>（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）</p>	
<p>2. 穿脫衣物</p> <p>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）.....（ ）</p> <p>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）.....（ ）</p> <p>2.3 穿脫鞋襪（包括手托或義肢）.....（ ）</p> <p>（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）</p>	
<p>3. 位置轉移</p> <p>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）</p> <p>請列出所需的輔助工具／助行器具：</p>	
<p>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</p> <p>（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「×」）</p>	
<p>5. 進食及進飲</p> <p>5.1 進食（倘若申請人使用導管餵食，請於分數括號內填上「×」）.....（ ）</p> <p>食物種類：*一般／切碎／糊狀</p> <p>進食輔助工具：*曲羹／粗柄羹／防滑墊／斜邊碟／其他：</p> <p>5.2 進飲（倘若申請人使用導管餵食，請於分數括號內填上「×」）.....（ ）</p> <p>進飲輔助工具：*飲管／雙耳杯／切口杯／有蓋啜飲杯／其他：</p> <p>（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）</p>	
<p>6. 室內行動能力（只需回答6.1或6.2）</p> <p>6.1 室內行走.....（ ）</p> <p>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：</p> <p>6.2 室內使用輪椅.....（ ）</p> <p>輪椅類別：*手動／電動</p> <p>（請選取適用的分項作為右方項目6的整項分數）</p>	
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：

<sup>3</sup> 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（如搥自己，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）： <input type="checkbox"/> 不恰當性行為 <input type="checkbox"/> 厭惡行為 <input type="checkbox"/> 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、智障人士或嚴重精神病患者
(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)、殘疾人士在職培訓計劃及展能中心(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）	
	中度弱智人士宿舍(HMMH)	
	嚴重弱智人士宿舍(HSMH)	
	嚴重肢體傷殘人士宿舍(HSPH)	
	嚴重殘疾人士護理院(C&A/SD)	
	療養院服務（評估員將向醫院管理局申請）	
	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。倘若申請人需申請社區支援服務、社區住宿服務或療養院服務，請轉填第 IX 部分並向有關機構提出申請。）

<p><u>日間訓練</u></p> <p>（須先完成本表格第 I 及 II 部分）</p>	<p><input type="checkbox"/> 庇護工場／綜合職業康復服務中心（為智障人士而設）</p> <p><input type="checkbox"/> 庇護工場／綜合職業康復服務中心（為肢體傷殘人士而設）</p> <p><input type="checkbox"/> 庇護工場／綜合職業康復服務中心（為弱視人士而設）</p> <p><input type="checkbox"/> 展能中心（為智障人士而設）</p> <p><input type="checkbox"/> 其他，請註明：</p>
<p><u>住宿／日間訓練及住宿服務</u></p> <p>（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）</p>	<p><input type="checkbox"/> 輔助宿舍（為智障人士而設） <input type="checkbox"/> 輔助宿舍（為智障及弱視人士而設）</p> <p><input type="checkbox"/> 輔助宿舍（為肢體傷殘人士而設）</p> <p><input type="checkbox"/> 嚴重肢體傷殘人士宿舍</p> <p><input type="checkbox"/> 中度弱智人士宿舍</p> <p><input type="checkbox"/> 庇護工場／綜合職業康復服務中心及中度弱智人士宿舍</p> <p><input type="checkbox"/> 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</p> <p><input type="checkbox"/> 展能中心及嚴重弱智人士宿舍</p> <p><input type="checkbox"/> 嚴重殘疾人士護理院（為智障或肢體傷殘人士而設）</p> <p><input type="checkbox"/> 其他，請註明：</p>
<p><u>私營殘疾人士院舍買位計劃<sup>註一</sup>下的住宿／日間訓練及住宿服務</u></p>	<p><input type="checkbox"/> 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、中度弱智人士宿舍、庇護工場／綜合職業康復服務中心及中度弱智人士宿舍的申請人）</p>

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
<p><input type="checkbox"/> 申請人沒有地區選擇</p> <p><input type="checkbox"/> 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：</p> <p>1. _____</p> <p>2. _____</p> <p>3. _____</p>	<p><input type="checkbox"/> 申請人沒有地區選擇，希望儘快入院舍</p> <p><input type="checkbox"/> 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：</p> <p>1. _____</p> <p>2. _____</p> <p>3. _____</p> <p>4. _____</p> <p>5. _____</p>

#### 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： \_\_\_\_\_

<sup>註一</sup>「買位院舍」即已參與「私營殘疾人士院舍買位計劃」的院舍

**RESTRICTED**  
**Confirmation of Registration**

From: Central Referral System for Rehabilitation Services  
Subsystem for the Mentally / Physically Handicapped  
Social Welfare Department  
6/F, West Coast International Building  
290-296 Un Chau Street, Sham Shui Po, Kowloon

To:

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

The following applicant has been registered in CRSRehab-MPH for rehabilitation service. Please kindly verify the following data, raise amendment and update any subsequent change to CRSRehab-MPH 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**

	<u>Score</u>		<u>Score</u>		<u>Score</u>
Skin Problem:	_____	Feeding Problem	_____	Medication:	_____
Continence Control:	_____	Epilepsy Condition:	_____	Oxygen Therapy:	_____
Suctioning:	_____	Bed Ridden:	_____	Special Nursing Care:	_____
					<b>Overall:</b>
					_____

**IV. Functional Impairment**

	<u>Score</u>		<u>Score</u>		<u>Score</u>
Bathing and Shampooing:	_____	Dressing and Undressing:	_____	Transfer:	_____
Toilet Use:	_____	Feeding and Drinking:	_____	Indoor Mobility:	_____
					<b>Overall:</b>
					_____

**V. Challenging Behaviour**

		<u>Score(s)</u>		
Aggressive Behaviours:	A1: _____	_____	A2: _____	
Self-injurious Behaviours:	B1: _____	_____	B2: _____	B3: _____
Property Destruction Behaviours:	C1: _____	_____	C2: _____	
Other Challenging Behaviours:	D: _____	_____		
Coping Difficulty:	E: _____	_____		
<b>Total scores on items A1, B1, C1 &amp; D:</b>	_____		<b>Total scores on items A2, B2, B3 and C2:</b>	_____
<b>Score on item E:</b>	_____			

**RESTRICTED**

**VI. Family Coping**

A1. Care System

<u>Types of carer</u>	<u>Name</u>	<u>Sex/Age</u>	<u>Relationship</u>	<u>Live Togthr.</u>	<u>Occupation/Wkg. Hr.</u>	<u>Care Hrs/Wk.</u>
(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 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 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:

Availability for day service:

Waiting List:

Location preference:

Day placement

Application date:

(i) Residential

(ii) Day

CRSRehab no.:

Residential placement

( )  
Oi/c CRSRehab-MPH

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 Services for People with Disabilities on \_\_\_\_\_ (Date). The assessment result is as follows:

- You are suitable for \_\_\_\_\_ service.
- Your residential services need is not confirmed. Hence, your application for residential services is rejected.
- You are not suitable for residential services for people with disabilities. Please apply to the Hospital Authority for Infirmity 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 Board for Standardised Assessment for Residential Services for People with Disabilities (Address: Room 901, Wu Chung House, 213 Queen's Road East, Wan Chai, Hong Kong) 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 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 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 \_\_\_\_\_ 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委員會秘書處**提出上訴，地址為：香港灣仔皇后大道東213號胡忠大廈901室。

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 the Mentally / Physically Handicapped  
 Social Welfare Department  
 6/F, West Coast International Building  
 290-296 Un Chau Street, Sham Shui Po, Kowloon

To:

CRSRehab-MPH 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-MPH Form 1* is returned to you for retention.

- Recommendation for residential services in Part VII E3 of *CRSRehab-MPH Form 1* is approved.
- Recommendation for residential services in Part VII E3 of *CRSRehab-MPH Form 1* is considered not justified; the applicant has been waitlisted residential service in accordance with the assessment result.
- The applicant is assessed to have no residential service need. Please apply for day training service/community support service as recommended by the assessment result.
- The residential 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 as recommended by the assessment result.

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

( \_\_\_\_\_ )  
 Oi/c CRSRehab-MPH



**RESTRICTED**

**Updating on Family Coping Condition**

From: _____ <i>(Name of Referring Office)</i>	To: Central Referral System for Rehabilitation Services Subsystem for the Mentally/Physically Handicapped Social Welfare Department 6/F, West Coast International Building 290-296 Un Chau Street Sham Shui Po, Kowloon
_____	
_____	
_____	
Ref.: _____	3586 3809 (DAC/HSMH/C&A/SD)
Tel.: _____	3586 3826 (SW/IVRSC/SHOS/HMMH/HSPH)
Fax: _____	Tel.: 3422 3995 (Inactive Waitlisting Mechansim)
Date: _____	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 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 physically/intellectually disabled person or has severe mental illness
(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 disabled or chronically ill persons 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： _____ (轉介單位)	致： 社會福利署 康復及醫務社會服務科 康復服務中央轉介系統-弱智／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
_____ (轉介機構)	
_____ (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、智障人士或嚴重精神病患者	
(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

**RESTRICTED**  
**Data Updating Form**

From: _____ <i>(Name of Referring Office)</i>	To: Central Referral System for Rehabilitation Services Subsystem for the Mentally / Physically Handicapped Social Welfare Department 6/F, West Coast International Building 290-296 Un Chau Street Sham Shui Po, Kowloon
_____	
_____	
Ref.: _____	3586 3809 (DAC/HSMH/C&A/SD)
Tel.: _____	3586 3826 (SW/IVRSC/SHOS/HMH/HSPH)
Fax: _____	Tel.: 3422 3995 (Inactive Waitlisting Mechanism)
Date: _____	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-MPH. Please give reason:
  - Applicant has passed away
  - Other reasons (please specify): \_\_\_\_\_
- Applicant is assessed to have other residential services need under the Standardised Assessment Mechanism.
- Applicant is not yet ready for admission to RCHD at the current stage. 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-MPH Form 1)
  - No change in the applicant's health condition (please also submit CRSRehab-MPH Form 1D)
- Change in placement request: \_\_\_\_\_
- Referring office is changed to: \_\_\_\_\_
- Change in request for HMMH [also apply for private home(s) under BPS#]
- Change in request for SW/IVRSC and HMMH [also apply for private home(s) under BPS#]
- Change in request for SHOS [also apply for private home(s) under BPS#]
- 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.): \_\_\_\_\_
- Applicant is discharged/ready for discharge\* from hospital. Please put the case back on active waiting list (for applicant waitlisting for single day rehabilitation service only).
- Applicant is ready for leaving the school. Please put the case back on active waiting list. Attached please find the updated CRSRehab-MPH Form 1 (for applicant waitlisting for single day rehabilitation service only).

CRSRehab No.: \_\_\_\_\_

Change in location preference:

Day placement

Residential placement

1. \_\_\_\_\_

1. \_\_\_\_\_

2. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

5. \_\_\_\_\_

Others, please specify (e.g. prefer day and residential service to be offered at the same time):

\_\_\_\_\_

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 the Mentally / Physically Handicapped  
 Social Welfare Department  
 6/F, West Coast International Building  
 290-296 Un Chau Street, Sham Shui Po, Kowloon

To:

--

CRSRehab-MPH Tel.:	3586 3809 / 3586 3826 / 3422 3995	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-MPH 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-MPH

**RESTRICTED**

**Transfer from Active Waiting List to Inactive Waiting List**

From: Central Referral System for Rehabilitation Services  
Subsystem for the Mentally / Physically Handicapped  
Social Welfare Department  
6/F, West Coast International Building  
290-296 Un Chau Street, Sham Shui Po, Kowloon

To:

CRSRehab-MPH Tel.: 3422 3995  
Fax: 3755 4946  
Date:

Your Ref.:  
Your Fax:

---

Name:

HKIC:

CRSRehab No.:

---

The residential 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 service on \_\_\_\_\_ is retained and can be reactivated upon submission of CRSRehab-MPH Form 3 and CRSRehab-MPH Form 1/Form1D.

( \_\_\_\_\_ )  
Oi/c CRSRehab-MPH



社會福利署  
康復及醫務社會服務科(長沙灣辦事處)  
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):

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。

社會福利署  
康復服務中央轉介系統

日期: \_\_\_\_\_

Central Referral System for Rehabilitation Services  
Subsystem for the Mentally/Physically Handicapped  
Social Welfare Department  
6/F., West Coast International Building,  
290-296 Un Chau Street,  
Sham Shui Po, Kowloon.

Date : \_\_\_\_\_

To: Applicants applying for transfer to the “Inactive Waiting List”  
(Via : Referring Social Worker)

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 to conduct regular review on your service needs.

Central Referral System for Rehabilitation Services  
Subsystem for the Mentally/Physically Handicapped  
Social welfare Department

## Report of Vacancies

<p>From: _____  <i>(Name of Rehabilitation Unit)</i></p> <p>_____</p> <p style="text-align: center;"><i>(Name of Organisation)</i></p> <p>_____</p> <p style="text-align: center;"><i>(Address of Rehabilitation Unit)</i></p> <p>Ref.: _____</p> <p>Tel.: _____</p> <p>Fax: _____</p> <p>Date: _____</p>	<p>To: Central Referral System for Rehabilitation Services          Subsystem for the Mentally / Physically Handicapped          Social Welfare Department          6/F., West Coast International Building          290-296 Un Chau Street          Sham Shui Po, Kowloon</p> <hr/> <p>3586 3809 (DAC/HSMH/C&amp;A/SD)          3586 3826 (SW/IVRSC/SHOS/HMH/HSPH)          Tel.: 3422 3995 (Inactive Waitlisting Mechansim)</p> <hr/> <p>Fax: 3755 4946</p>
---	---

1. Number of vacancies as at \_\_\_\_\_ (date):

Service	Day only	Residential only		Day cum residential	
		M	F	M	F
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-MPH 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	
		M	F	M	F
Vacancies					
Available date(s)					
Remarks					

Signature: \_\_\_\_\_

Name: \_\_\_\_\_

Post: \_\_\_\_\_

**RESTRICTED**

**Selection for Placement**

From: Central Referral System for Rehabilitation Services  
Subsystem for the Mentally / Physically Handicapped  
Social Welfare Department  
6/F, West Coast International Building  
290-296 Un Chau Street, Sham Shui Po, Kowloon

To:

CRSRehab-MPH Tel.: 3586 3809 / 3586 3826  
Fax: 3755 4946  
Date:

Your Ref.:  
Your Tel:  
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:

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. Form 7
3. Medical report
4. Case Summary

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 authorized by the applicant during the application process.

( \_\_\_\_\_ )  
Oi/c CRSRehab-MPH

**RESTRICTED**

**Notification of Case Selection to Rehabilitation Unit**

From: Central Referral System for Rehabilitation Services  
Subsystem for the Mentally / Physically Handicapped  
Social Welfare Department  
6/F, West Coast International Building  
290-296 Un Chau Street, Sham Shui Po, Kowloon

To:

CRSRehab-MPH Tel.: 3586 3809 / 3586 3826  
Fax: 3755 4946  
Date:

Your Ref.:  
Your Fax:

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.

<u>Name</u>	<u>Gender/ Age</u>	<u>CRSRehab No.</u>	<u>Referring Office</u>	<u>Name of Referrer</u>	<u>Tel</u>	<u>Normal/ Priority</u>
-------------	------------------------	-------------------------	-------------------------	-----------------------------	------------	-----------------------------

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-MPH

**RESTRICTED**

**Reply to CRSRehab-MPH 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 the Mentally / Physically Handicapped  
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/HMH/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 service under the Standardised Assessment Mechanism \***. (For priority placement, the applicant is confirmed to have urgent service need.)

The following documents are attached:

- |  |   |
|--|---|
| <input type="checkbox"/> CRSRehab-MPH Form 1                                       | <input type="checkbox"/> Case summary                   |
| <input type="checkbox"/> Psychological/psychiatric/medical* report                 | <input type="checkbox"/> Medical Examination Form (MEF) |
| <input type="checkbox"/> School progress/VTC* report/Occupational Therapist report | <input type="checkbox"/> Certificate of blindness       |

- Applicant is assessed to have no residential service need under the Standardised Assessment Mechanism. Case can be deleted from CRSRehab-MPH.**
- Applicant is assessed to have residential service need under the Standardised Assessment Mechanism but he/she is not yet ready for admission to RCHD at the current stage. 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 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 at present.
- Applicant is attending special school at present.
- Applicant is residing in self-financing or private home.
- The placement offer does not match applicant's service request or location preference.
- 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:

Diagnosis/Treatment required:

**Please transfer the Applicant to the inactive waiting list if he/she is waitlisting for pair-up or residential service.**

**(for day and residential service applicant only) Applicant prefers that day service be offered with residential placement together.**

Signature: \_\_\_\_\_

Name: \_\_\_\_\_

Post: \_\_\_\_\_

*\* Please delete as inapplicable*





**RESTRICTED**

**Reminder to Referrer**  
**(for Annual Case Review)**

From: Central Referral System for Rehabilitation Services  
Subsystem for the Mentally / Physically Handicapped  
Social Welfare Department  
6/F, West Coast International Building  
290-296 Un Chau Street, Sham Shui Po, Kowloon

To:

CRSRehab-MPH Tel.: 3422 3995  
Fax: 3755 4946  
Date:

Your Ref.:  
Your Tel:  
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-MPH via *Form 3* **within 3 weeks**.

( )  
O/c CRSRehab-MPH

**RESTRICTED****Referral for Admission**

From: Central Referral System for Rehabilitation Services  
 Subsystem for the Mentally / Physically Handicapped  
 Social Welfare Department  
 6/F, West Coast International Building  
 290-296 Un Chau Street, Sham Shui Po, Kowloon

To:

--

CRSRehab-MPH Tel.: 3586 3809 / 3586 3826  
 Fax: 3755 4946  
 Date:

Your Ref.:  
 Your Fax:

**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:  
 Gender / D.O.B.:

Hong Kong Identity Card:  
 CRSRehab No.:

**Referral papers attached:**

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

( )  
 Oi/c CRSRehab-MPH

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 the Mentally / Physically Handicapped  
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/HMH/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 (applicable to day services only):
  - 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                       living in private / self-financing home
  - supported employment                       prefer to live with / cared by family member(s)
  - unfavourable location                       attending special school at present
  - lost contact                       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 service of the same type
  - admitted to other type of day / residential service due to improvement of ability, pl. specify: \_\_\_\_\_
  - admitted to other type of day / residential service due to deterioration, pl. specify: \_\_\_\_\_
  - admitted to hospital (including psychiatric hospital) for more than 2 months
  - admitted infirmary                       compassionate rehousing or independent living
  - return home or family union                       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 the Mentally / Physically Handicapped  
 Social Welfare Department  
 6/F, West Coast International Building  
 290-296 Un Chau Street, Sham Shui Po, Kowloon

To:

--

CRSRehab-MPH Tel.: 3586 3809 / 3586 3826

Fax: 3755 4946

Date:

Your Ref.:

Your Fax:

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 ReferralCRSRehab No.Name of ApplicantGenderAge

( )

O/c CRSRehab-MPH

c.c. Agency Head  
 Referrer:

### Application for Priority Placement

<p>From: _____  <small>(Name of Referring Office)</small></p> <p>_____</p> <p style="text-align: center;"><small>(Name of Organization)</small></p> <p>_____</p> <p style="text-align: center;"><small>(Address of Referring Office)</small></p> <p>Ref.: _____</p> <p>Tel.: _____</p> <p>Fax: _____</p> <p>Date: _____</p>	<p>To: Central Referral System for Rehabilitation Services          Subsystem for the Mentally/Physically Handicapped          Social Welfare Department          6/F, West Coast International Building          290-296 Un Chau Street          Sham Shui Po, Kowloon</p> <hr/> <p style="text-align: center;">3586 3809 (DAC/HSMH/C&amp;A/SD)</p> <p>Tel.: 3586 3826 (SW/IVRSC/SHOS/HMH/HSPH)</p> <hr/> <p>Fax: 3755 4946</p>
---	--

**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).**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**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: \_\_\_\_\_

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

**RESTRICTED**

**Outcome of Application for Priority Placement**

From: Central Referral System for Rehabilitation Services  
Subsystem for the Mentally / Physically Handicapped  
Social Welfare Department  
6/F, West Coast International Building  
290-296 Un Chau Street, Sham Shui Po, Kowloon

To:

CRSRehab-MPH Tel.: 3586 3809 / 3586 3826  
Fax: 3755 4946  
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-MPH



殘疾人士住宿服務評估  
上訴申請書

致：殘疾人士住宿服務評估  
上訴委員會秘書處  
九龍深水埗元州街290-296號西岸國際大廈6樓

本人 \_\_\_\_\_ (\*服務申請人／服務申請人家人／服務申請人監護人)就  
殘疾人士住宿服務評估結果提出上訴，理由如下：

---

---

---

---

---

本人明白有關服務申請人的個人資料，將會透露給調解小組及上訴委員會作處理  
上訴申請之用。

簽名： \_\_\_\_\_  
上訴申請人姓名： \_\_\_\_\_  
身份証號碼： \_\_\_\_\_  
地址： \_\_\_\_\_  
\_\_\_\_\_

電話： \_\_\_\_\_  
傳真： \_\_\_\_\_  
日期： \_\_\_\_\_

\*刪去不適用者

**CENTRAL REFERRAL SYSTEM FOR REHABILITATION SERVICES  
SUBSYSTEM FOR THE EX-MENTALLY ILL (CRSRehab-ExMI)  
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 (D/M/Y) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
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	1 <sup>st</sup> Location Preference	2 <sup>nd</sup> Location Preference	3 <sup>rd</sup> Location Preference
B <input type="checkbox"/>	Sheltered Workshop			
	For internal use only			

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

Code	Service Type	1 <sup>st</sup> Location Preference	2 <sup>nd</sup> Location Preference	3 <sup>rd</sup> Location Preference
C <input type="checkbox"/>	Halfway house [Subvented]			
L <input type="checkbox"/>	Halfway house [Subvented + Bought Place Scheme for Private Residential Care Homes for Persons with Disabilities]			
E <input type="checkbox"/>	Halfway house with special provision (previously known as Purpose-built Halfway House)			
G <input type="checkbox"/>	Long Stay Care Home [Subvented]			
H <input type="checkbox"/>	Long Stay Care Home [Subvented + Bought Place Scheme for Private Residential Care Homes for Persons with Disabilities]			
I <input type="checkbox"/>	Supported Hostel [Subvented]			
N <input type="checkbox"/>	Supported Hostel [Subvented + Bought Place Scheme for Private Residential Care Homes for Persons with Disabilities]			
	For internal use only			

**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 discharges 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.

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

\*Please delete as appropriate

**RESTRICTED****Confirmation of Registration**

From: Central Referral System for Rehabilitation Services  
 Subsystem for the Ex-Mentally Ill  
 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-ExMI for rehabilitation service. I now return your original Form 1. Please kindly verify the following data, raise amendment and update any subsequent change to CRSRehab-ExMI 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.

**A. Information of referrer:**

Tel No.:

Fax No.:

**B. Case particulars**

Name:

姓名:

Sex:

:

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:

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

Status of day service:

Status of res.  
service:

Offer at the same time:

**D. Status of application:**

Priority (day/residential) :

/

Name: \_\_\_\_\_

Post: Oi/c CRSRehab - ExMI

Date of issue: \_\_\_\_\_

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.): \_\_\_\_\_

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: \_\_\_\_\_ ( ) HKID: \_\_\_\_\_ Sex / Age: \_\_\_\_\_ / \_\_\_\_\_  
D.O.B.: \_\_\_\_/\_\_\_\_/\_\_\_\_ (DD/MM/YYYY) CRSRehab no.: D\_\_\_\_\_ 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 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 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): \_\_\_\_\_  
Office / Centre: \_\_\_\_\_  
Telephone no.: \_\_\_\_\_ ext.: \_\_\_\_\_  
Date: \_\_\_\_\_

(Signature): \_\_\_\_\_  
Agency: \_\_\_\_\_  
Fax no.: \_\_\_\_\_

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.: D \_\_\_\_\_ 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) \_\_\_\_\_  
 Tel. no.: \_\_\_\_\_ ext: \_\_\_\_\_

Name in BLOCK: \_\_\_\_\_  
 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.: D \_\_\_\_\_ Hospital / Clinic ref. no.: \_\_\_\_\_  
Hospital / Clinic: \_\_\_\_\_

**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	<input type="checkbox"/>	●
	2. Need prompting	<input type="checkbox"/>	
	3. Able to look after personal hygiene independently	<input type="checkbox"/>	
<hr/>			
B. Cooperation in ward life:	1. Not willing to do his share	<input type="checkbox"/>	●
	2. Willing to do his share but no more	<input type="checkbox"/>	
	3. Willing to do more than his share	<input type="checkbox"/>	
<hr/>			
C. Drug compliance:	1. Shows strong reluctance even being prompted	<input type="checkbox"/>	●
	2. Take medication when being advised	<input type="checkbox"/>	
	3. Take medication on his own initiative	<input type="checkbox"/>	
<hr/>			
D. Social mixing / Ward life:	1. Withdraws from social mixing	<input type="checkbox"/>	●
	2. Mixes with other in organized groups only	<input type="checkbox"/>	
	3. Mixes with others spontaneously	<input type="checkbox"/>	
<hr/>			
E. Attitude towards placement:	1. Resists the idea	<input type="checkbox"/>	●
	2. Will do whatever is suggested	<input type="checkbox"/>	
	3. Welcomes the idea	<input type="checkbox"/>	
<hr/>			
F. Money management:	1. Spends appropriately	<input type="checkbox"/>	●
	2. Reluctant to spend	<input type="checkbox"/>	
	3. Fails to keep money	<input type="checkbox"/>	
<hr/>			
G. Nursing care dependency:	1. Intensive nursing care needed	<input type="checkbox"/>	●
	2. Medium level of nursing care needed	<input type="checkbox"/>	
	3. Minimum nursing care needed	<input type="checkbox"/>	
<hr/>			
H. Overall comment:	_____		
<hr/>			
I. Other remarks:	_____		
<hr/>			

Referring nurse: (Signature) \_\_\_\_\_  
Tel. no.: \_\_\_\_\_ ext: \_\_\_\_\_

Name in BLOCK: \_\_\_\_\_  
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.: D\_\_\_\_\_ Hospital / Clinic ref. no.: \_\_\_\_\_  
 Hospital / Clinic: \_\_\_\_\_

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

General performance		<i>(please √ as appropriate)</i>			
		V. Good	Good	Fair	Poor
A.	<b><u>Household management skills</u></b>				
	Meal preparation skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Laundry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Household cleansing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Home safety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B.	<b><u>Community living</u></b>				
	Use of community resources	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Use of transportation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Road safety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Money management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C.	<b><u>Work performance</u></b>				
	Attendance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Punctuality	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Concentration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Following instructions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Work motivation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Work tolerance and endurance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Work skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D.	<b><u>Social behavior</u></b>				
	Cleanliness / Appearance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Getting along with others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Cooperation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Special vocational skill / interest: \_\_\_\_\_

In view of the applicant's employment record and present work capability, the applicants work potential can reach :  
 Training and activity center/  Sheltered workshop/  Supported employment/  Part time employment/  Full employment.

Other remarks: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Referring OT: (Signature) \_\_\_\_\_  
 Tel. no.: \_\_\_\_\_ ext: \_\_\_\_\_

Name in BLOCK: \_\_\_\_\_  
 Ward / Team / Unit: \_\_\_\_\_ Date: \_\_\_\_\_

**RESTRICTED**  
**Data Updating Form**

From: _____ <i>(Name of Referring Office)</i>	To: Central Referral System for Rehabilitation Services Subsystem for the Ex-Mentally Ill Social Welfare Department Room 901, 9/F Wu Chung House 213 Queen's Road East, Wanchai, Hong Kong
Ref.: _____ <i>(Name of Organization)</i>	Your Ref.:
Tel.: _____	Tel.: 2892 5136
Fax: _____	Fax: 2893 6983
Date: _____	

Name: \_\_\_\_\_ HKIC: \_\_\_\_\_ CRSRehab no.: D

Information to be updated: (✓ in the box)

- Placement is no longer required. Case can be closed from CRSRehab - ExMI.
- Change in placement request: Day placement:  
Residential placement: (please tick suitable items)
  - SHOS (Subvented)       SHOS (Subvented + BPS\*)
  - HWH (Subvented)       HWH (Subvented + BPS\*)       HWH(SP)
  - LSCH (Subvented)       LSCH (Subvented + BPS\*)
- Referring office changes to: \_\_\_\_\_
- Name of referrer changes to: \_\_\_\_\_
- Change in applicant's personal particulars (residential district, disability, etc.);
- Intensive care case**       **Non-intensive care case**      *(this part must be completed)*
- Case discharged on (DD/MM/YYYY)      \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_
- Discharge reason is: \_\_\_\_\_
- Change in location preference:  
Day placement      Residential placement
- Others, please specify:

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

Signature: \_\_\_\_\_  
Name in BLOCK: \_\_\_\_\_  
Post: \_\_\_\_\_

c.c. New referrer (for report of change of referrer):

**RESTRICTED****Removal from Waiting List**

From: Central Referral System for Rehabilitation Services  
Subsystem for the Ex-Mentally Ill  
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-ExMI 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 - ExMI  
)



**RESTRICTED**  
**Selection for Placement**

CRSRehab-ExMI Form 6

**PART I**

From: Oi/c CRSRehab - ExMI To: Referrer:  
CRSRehab No.: Your Ref. No.:  
Tel. No.: Name of Applicant:  
Fax No.: 姓名: HKIC:  
Date: Fax No.:

The above-named has been selected to the following rehabilitation unit. Please complete Part II and return to CRSRehab-ExMI within 2 week(s). You are advised to prepare the following document(s) and send to the following unit directly. (For priority placement, please review and confirm the applicant still has urgent service need.)

Centre: Tel. No.  
Address: Fax No.

**Document(s) to be sent to service unit:**

1. Standard Agency Application Form (CRSRehab-ExMI Form 2)
2. Chest X-Ray Report

Signature: \_\_\_\_\_ ( ) Post: Oi/c CRSRehab - ExMI

---

**PART II** **Reply to CRSRehab-ExMI on Selection for Placement**

CRSRehab-ExMI Form 7

**(be completed by Referrer and sent back to CRSRehab-ExMI)**

From: To:

The applicant **Accepts** (For priority placement, the applicant is confirmed to have urgent service need.) / **Declines** \* the placement offered.

(\* Please delete as appropriate)

I **confirm** that all relevant documents requested in Part I have already been sent to the service unit for further action on \_\_\_/\_\_\_/\_\_\_

*If the client declines the offer, please tick **ONE MOST SIGNIFICANT** reason in the box below:*

- Prefer to have day and residential placement at the same time
- Unfavourable location
- Ill health / unstable mental or emotional condition
- Temporary leave of Hong Kong / emigration
- Open / supported employment
- Lost trace of client
- 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: \_\_\_\_\_
- Hospitalization (not applicable to the applicants who are admitted to psychiatric hospital or psychiatric ward of general hospital) on \_\_\_\_\_ in \_\_\_\_\_  
due to \_\_\_\_\_
- Others, (please specify): \_\_\_\_\_

Please update case status: (For cases declining the offer only)

- No longer need CRSRehab-ExMI service, case can be **DELETED** from CRSRehab-ExMI **PERMANENTLY**  
(Case deletion only for deceased case or transfer to waiting list of other services not under CRSRehab-ExMI.)

Please update the following information:

Reply by : \_\_\_\_\_ Office: \_\_\_\_\_  
( ) Date: \_\_\_\_\_  
Tel. No.: \_\_\_\_\_ Fax No.: \_\_\_\_\_

**RESTRICTED****Notification of Case Selection to Rehabilitation Unit**

From: Central Referral System for Rehabilitation Services  
 Subsystem for the Ex-Mentally Ill  
 Social Welfare Department  
 Room 901, 9/F Wu Chung House  
 213 Queen's Road East, Wanchai, Hong Kong

To:

--

CRSRehab Tel.:  
 Fax:  
 Date:

Your Tel:  
 Your Fax:

---

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 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.

<u>Name</u>	<u>Gender/ Age</u>	<u>CRSRehab No.</u>	<u>Referring Office</u>	<u>Name of Referrer</u>	<u>Tel</u>	<u>Normal/ Priority</u>
-------------	------------------------	-------------------------	-----------------------------	-------------------------	------------	-----------------------------

(  
 Oi/c CRSRehab - ExMI  
 )

**RESTRICTED**  
**Reminder to Referrer**

**PART I****Notification of Referral (Reminder)**

From: Oi/c CRSRehab - ExMI To: Referrer:  
 CRSRehab No.: Your Ref. No.:  
 Tel. No.: Applicant:  
 Fax No.: 姓名: HKIC:  
 Date: Fax No.:

The above-named has been selected to the following rehabilitation unit. Please complete Part II and return to CRSRehab-ExMI within 1 week(s). You are advised to prepare the following document(s) and send to the following unit directly. (For priority placement, please review and confirm the applicant still has urgent service need.

Centre: Tel. No.  
 Address: Fax No.

- Document(s) to be sent to service unit:**
1. Standard Agency Application Form (CRSRehab-ExMI Form 2)
  2. Chest X-Ray Report

Signature: \_\_\_\_\_ ( ) Post: Oi/c CRSRehab - ExMI

**PART II****Reply to CRSRehab-ExMI**

CRSRehab-ExMI Form 7

**(be completed by Referrer and sent back to CRSRehab-ExMI)**

From: To:

The applicant **Accepts** (For priority placement, the applicant is confirmed to have urgent service need.) / **Declines \*** the placement offered. (\* Please delete as appropriate)

I **confirm** that all relevant documents requested in Part I have already been sent to the service unit for further action on \_\_/\_\_/\_\_\_\_

If the client declines the offer, please tick **ONE MOST SIGNIFICANT** reason in the box below :

- Prefer to have day and residential placement at the same time
- Unfavourable location
- Ill health / unstable mental or emotional condition
- Temporary leave of Hong Kong / emigration
- Open / supported employment
- Lost trace of client
- 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: \_\_\_\_\_
- Hospitalization (not applicable to the applicants who are admitted to psychiatric hospital or psychiatric ward of general hospital)  
 on \_\_\_\_\_ in \_\_\_\_\_  
 due to \_\_\_\_\_
- Others, (please specify): \_\_\_\_\_

Please update case status: (For cases declining the offer only)

- No longer need CRSRehab-ExMI service, case can be **DELETED** from CRSRehab-ExMI **PERMANENTLY**  
 (Case deletion only for deceased case or transfer to waiting list of other services not under CRSRehab-ExMI.)

Please update the following information:

Reply by: \_\_\_\_\_ Office: \_\_\_\_\_  
 ( ) Date: \_\_\_\_\_  
 Tel. No. \_\_\_\_\_ Fax No. \_\_\_\_\_

c.c. Supervisor

**RESTRICTED**  
**Reminder to Referrer**

**PART I****Notification of Referral (Second Reminder)**

From: Oi/c CRSRehab - ExMI	To: Referrer:	
CRSRehab No.:	Your Ref. No.:	
Tel. No.:	Applicant:	
Fax No.:	姓名:	HKIC:
Date:	Fax No.:	

The above-named has been selected to the following rehabilitation unit. Please complete Part II and return to CRSRehab-ExMI within 1 week(s). You are advised to prepare the following document(s) and send to the following unit directly. (For priority placement, please review and confirm the applicant still has urgent service need.)

Centre:	Tel. No.
Address:	Fax No.

**Document(s) to be sent to service unit:**

1. Standard Agency Application Form (CRSRehab-ExMI Form 2)
2. Chest X-Ray Report

Signature: \_\_\_\_\_ ( ) Post: Oi/c CRSRehab - ExMI

**PART II****Reply to CRSRehab-ExMI**

CRSRehab-ExMI Form 7

**(be completed by Referrer and sent back to CRSRehab-ExMI)**

From: \_\_\_\_\_ To: \_\_\_\_\_

The applicant **Accepts** (For priority placement, the applicant is confirmed to have urgent service need.) / **Declines** \* the placement offered. (\* Please delete as appropriate)

I **confirm** that all relevant documents requested in Part I have already been sent to the service unit for further action on \_\_\_/\_\_\_/\_\_\_

If the client declines the offer, please tick **ONE MOST SIGNIFICANT** reason in the box below :

- Prefer to have day and residential placement at the same time
- Unfavourable location
- Ill health / unstable mental or emotional condition
- Temporary leave of Hong Kong / emigration
- Open / supported employment
- Lost trace of client
- 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: \_\_\_\_\_
- Hospitalization (not applicable to the applicants who are admitted to psychiatric hospital or psychiatric ward of general hospital)  
on \_\_\_\_\_ in \_\_\_\_\_  
due to \_\_\_\_\_
- Others, (please specify): \_\_\_\_\_

Please update case status: (For cases declining the offer only)

- No longer need CRSRehab-ExMI service, case can be **DELETED** from CRSRehab-ExMI **PERMANENTLY**  
(Case deletion only for deceased case or transfer to waiting list of other services not under CRSRehab-ExMI.)

Please update the following information:

Reply by: _____	Office: _____
( )	Date: _____
Tel. No. _____	Fax No. _____



REFERRAL FOR ADMISSION

List of Application

PART I

From: Oi/c CRSRehab - ExMI To:
Tel. No.:
Fax No.:
Date: Fax No.:
Name of Applicant: HKIC: CRSRehab-ExMI No.:

I forward the captioned application for admission to your unit. Please reply within 2 week(s) by completing Part II.

Signature: ( ) Post: Oi/c CRSRehab - ExMI

PART II

Report on Case Intake

(be completed by Rehabilitation Unit and sent / faxed back to CRSRehab-ExMI)

From: To:

The application of \_\_\_\_\_ has been processed and the result is as follows:

Admitted with date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ (DD/MM/YYYY)

Rejected with reason: (Please [X] ONE MOST SIGNIFICANT reason)

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

Applicant self-withdrawal with reason: (Please [X] ONE MOST SIGNIFICANT reason)

- unfavorable location
refuse to attend pre-admission interview upon approach
lost trace
claim to have no day and / or residential need
open employment / supported employment ( for applicant of sheltered workshop / activity centre training programme only )
prefer to live with family / take care of family members
the family rejects the placement offer
refuse to follow the regulation of the rehabilitation unit
prefer another type of services
self-withdrawal and refuse to give reason
Hospitalization (not applicable to the applicants who are admitted to psychiatric hospital or psychiatric ward of general hospital) on \_\_\_\_\_ in \_\_\_\_\_ due to \_\_\_\_\_
others, please specify :

Reserved (Please [X] as appropriate)

- no immediate vacancy but would be admitted within 1 month and admission is scheduled on \_\_\_\_\_

Signature: \_\_\_\_\_ Post: \_\_\_\_\_ Date: \_\_\_\_\_

Reply by: ( )

Tel no.: \_\_\_\_\_ Fax no.: \_\_\_\_\_

c.c. referrer: \_\_\_\_\_, (Fax no.: \_\_\_\_\_)

**RESTRICTED**  
**Reminder to Rehabilitation Unit**

**PART I****List of Application (Reminder)**

From: Oi/c CRSRehab - ExMI To:

Tel. No.:

Fax No.:

Date: Fax. No.:

Applicant: HKIC: CRSRehab No.:

( )

I forward the captioned application for admission to your unit. Please reply within 1 week(s) by completing **Part II**.

Signature: \_\_\_\_\_ ( ) Post: Oi/c CRSRehab - ExMI

**PART II****Notification of Result**

CRSRehab-ExMI Form 9

**(be completed by Rehabilitation Unit and sent / faxed back to CRSRehab-ExMI)**

From: To:

The application of \_\_\_\_\_ has been processed and the result is as follows:

Admitted with date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ (DD/MM/YYYY)

**Attention**

Please be aware that if CRSRehab-ExMI does not receive a concrete reply ***within 1 week(s)*** from the date of this form issued, ***second reminder will be issued***. The case will be regarded as a rejected case if no concrete reply received within (1 week(s)) after the second reminder is issued.

**Rejected with reason:** (Please  **ONE MOST SIGNIFICANT** reason)

- no vacancy  
 low ability / no motivation for training  
 severe behavioral problem, please specify: \_\_\_\_\_  
 health problem  
 unstable mental / emotional condition  
 others, please specify: \_\_\_\_\_

**Applicant self-withdrawal with reason:** (Please  **ONE MOST SIGNIFICANT** reason)

- unfavorable location  
 refuse to attend pre-admission interview upon approach  
 lost trace  
 claim to have no day and / or residential need  
 open employment / supported employment ( for applicant of sheltered workshop / activity centre training programme only )  
 prefer to live with family / take care of family members  
 the family rejects the placement offer  
 refuse to follow the regulation of the rehabilitation unit  
 prefer another type of services  
 self-withdrawal and refuse to give reason  
 Hospitalization (not applicable to the applicants who are admitted to psychiatric hospital or psychiatric ward of general hospital) on \_\_\_\_\_ in \_\_\_\_\_ due to \_\_\_\_\_  
 others, please specify: \_\_\_\_\_

Reserved (Please  as appropriate) no immediate vacancy but would be admitted within 1 month and admission is scheduled on \_\_\_\_\_

Signature: \_\_\_\_\_ Post: \_\_\_\_\_ Date: \_\_\_\_\_

Reply by: ( )

Tel. no.: \_\_\_\_\_ Fax no.: \_\_\_\_\_

c.c. Supervisor

**RESTRICTED**  
**Second Reminder to Rehabilitation Unit**

CRSRehab-ExMI Form 9B

**PART I**

**List of Application (Second Reminder)**

From: Oi/c CRSRehab - ExMI To:  
Tel. No.:  
Fax No.:  
Date: Fax. No.:

Applicant: ( ) HKIC: CRSRehab No.:

I forward the captioned application for admission to your unit. Please reply within 1 week(s) by completing **Part II**.

Signature: \_\_\_\_\_ ( ) Post: Oi/c CRSRehab - ExMI

---

**PART II**

**Notification of Result**

CRSRehab-ExMI Form 9

**(be completed by Rehabilitation Unit and sent / faxed back to CRSRehab-ExMI)**

From: To:

The application of \_\_\_\_\_ has been processed and the result is as follows:

Admitted with date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ (DD/MM/YYYY)

**Attention**

Please be aware that if CRSRehab-ExMI does not receive a concrete reply ***within 1 week(s)*** from the date of this form issued, the case will be ***regarded as a rejected case***.

**Rejected with reason:** (Please  **ONE MOST SIGNIFICANT** reason)

- no vacancy
- low ability / no motivation for training
- severe behavioral problem, please specify : \_\_\_\_\_
- health problem
- unstable mental / emotional condition
- others, please specify: \_\_\_\_\_

**Applicant self-withdrawal with reason:** (Please  **ONE MOST SIGNIFICANT** reason)

- unfavorable location
- refuse to attend pre-admission interview upon approach
- lost trace
- claim to have no day and / or residential need
- open employment / supported employment ( for applicant of sheltered workshop / activity centre training programme only )
- prefer to live with family / take care of family members
- the family rejects the placement offer
- refuse to follow the regulation of the rehabilitation unit
- prefer another type of services
- self-withdrawal and refuse to give reason
- Hospitalization (not applicable to the applicants who are admitted to psychiatric hospital or psychiatric ward of general hospital) on \_\_\_\_\_ in \_\_\_\_\_ due to \_\_\_\_\_
- others, please specify : \_\_\_\_\_

Reserved (Please  ***as appropriate***)

- no immediate vacancy but would be admitted within 1 month and admission is scheduled on \_\_\_\_\_

Signature: \_\_\_\_\_ Post: \_\_\_\_\_ Date: \_\_\_\_\_  
Reply by: ( )  
Tel. no.: \_\_\_\_\_ Fax no.: \_\_\_\_\_

c.c. Agency Head

### Application for Priority Placement

From: _____ <i>(Name of Referring Office)</i> _____ <i>(Name of Organization)</i>	To: Central Referral System for Rehabilitation Services Subsystem for the Ex-mentally Ill Room 901, 9/F Wu Chung House 213 Queen's Road East Wanchai, Hong Kong
Our Ref.: _____	Your Ref.: _____
Tel.: _____	Tel.: 2892 5136
Fax: _____	Fax: 2893 6983
Date: _____	

**1. Case particulars**

Name: \_\_\_\_\_ Sex/D.O.B.: \_\_\_\_\_ HKID No.: \_\_\_\_\_  
Address: \_\_\_\_\_ Tel.: \_\_\_\_\_  
Diagnosis: \_\_\_\_\_  
Placement(s) required: \_\_\_\_\_ CRSRehab No.:   D  

**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-government organizations or DSWO/ADSWO of SWD.

**RESTRICTED**

**Outcome of Application for Priority Placement**

From: Central Referral System for Rehabilitation Services  
Subsystem for the Ex-Mentally Ill  
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 - ExMI  
)

# RESTRICTED

## Central Referral System for Rehabilitation Services Subsystem for the Aged Blind (CRSRehab-AB) Data Input Form

**Person aged 60 or above and is certified as total blindness or with severe low vision is eligible to apply for the service of 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:

- Total blindness
  - Severe grade low vision
- } 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

8.5 Welfare Assistance Currently Receiving:

- Disability Allowance
- Comprehensive Social Security Assistance
- Old Age Allowance
- Enhanced Home and Community Care Services / Home Help 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.: \_\_\_\_\_

(for contacting the referrer)

I, the Responsible Officer, hereby confirm that 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 his / her application for admission to residential care services for the elderly and for related purposes.

**PART D Declaration**

I also declare that I have no conflict of interest in handling this application. I am not a family member or personal friend of the applicant and have no personal or social ties with the applicant.

Signature: \_\_\_\_\_

Name of Responsible Officer: \_\_\_\_\_

Date: \_\_\_\_\_

**Supervisor's Endorsement**

I have examined the case file as well as information provided in this referral form, and am satisfied that the applicant is in need of service of care and attention home for the aged blind.

Signature: \_\_\_\_\_

Name of Supervisor: \_\_\_\_\_

Date: \_\_\_\_\_



**RESTRICTED****Confirmation of Registration**

From: Central Referral System for Rehabilitation Services  
 Subsystem for the Aged Blind (CRSRehab-AB)  
 Social Welfare Department  
 Room 901, 9/F Wu Chung House,  
 213 Queen's Road East, Wanchai, Hong Kong

To:

--

CRSRehab-AB Tel.:  
 Fax:  
 Date:

Your Ref.:  
 Your Fax:

The following applicant has been registered in CRSRehab-AB for rehabilitation service. I now return the original Form 1. Please kindly verify the following data, raise amendment and update any change to CRSRehab-AB 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

Mobility:

Impairment:

Mental State:

Incontinence

**IV. Placement Request**

Type of placement:

CRSRehab-AB no.

Application date:

Status of service:

Location preference:

**V. Status of applicant:** Priority :

(  
 Oi/c CRSRehab - AB  
 )

**限閱文件**  
**RESTRICTED**

社會福利署  
康復服務中央轉系統  
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.): \_\_\_\_\_

**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**

<b>第一部</b> <b>Part I :</b>	<b>申請表格〔由申請人簽署〕</b> <b>Application Form (to be signed by applicant)</b>
(甲) (A)	<b>獲編配盲人護理安老院名稱:</b> <b>Name of Care and Attention Home for the Aged Blind to be Allocated:</b>  _____
(乙) (B)	<b>申請人資料:</b> <b>Particulars of Applicant:</b> 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) (C)	<b>申請人同意書</b> <b>Applicant's Written Consent</b>  本人同意將所附資料，包括視力和體格檢驗結果及本人之社會背景紀錄，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, medical 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 _____ Signed : _____ 日期 _____ Date : _____

**Part II: Case Summary (to be completed by referring social 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 of RCHE): \_\_\_\_\_

Others (please specify): \_\_\_\_\_  
\_\_\_\_\_

**(D) Physical and Mental Condition:**

Obvious disability (such as amputation, spastic):

---

Hearing for Normal Communication:

Adequate     Inadequate     Deaf

Speech:

Adequate                       Speech Defect (please elaborate) : \_\_\_\_\_  
 No speech

Incontinence:                      Yes      No

Urine                                           

Faeces                                         

Mental State:

Normal/alert                       Senile dementia                       Others (please specify): \_\_\_\_\_

With disturbing behaviour (please elaborate): \_\_\_\_\_

Mobility:

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

**(E) Daily Living Activities:**

	<u>Fully Capable</u>	<u>Partially Dependent on Others</u>	<u>Totally Dependent on Others</u>
Bathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Washing face / hands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Toileting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**(F) Brief Social History / Additional Remarks**

**(G) Source of Referral**

Referring agency : \_\_\_\_\_

Referring office : \_\_\_\_\_

Address : \_\_\_\_\_

\_\_\_\_\_

File Ref. No. : \_\_\_\_\_ Fax No. : \_\_\_\_\_

Referring Social Worker

Countersigning Officer

Signature : \_\_\_\_\_

Signature : \_\_\_\_\_

Name : \_\_\_\_\_

Name : \_\_\_\_\_

Post : \_\_\_\_\_

Post : \_\_\_\_\_

Tel. No. : \_\_\_\_\_

Tel. No. : \_\_\_\_\_

Date : \_\_\_\_\_

Date : \_\_\_\_\_

Email address : \_\_\_\_\_

**Part III: Medical Examination Form (to be completed by registered medical practitioner)**

Name of applicant: \_\_\_\_\_ Sex : \_\_\_\_\_ Age : \_\_\_\_\_

HKID No.: \_\_\_\_\_

Hospital / Clinic : \_\_\_\_\_

Ref. No. (if any) : \_\_\_\_\_

**History of major disease and operation:**

---

---

---

**Health Problem(s):**

	Yes	No	Unknown		Yes	No	Unknown
Head & Neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Limbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chest	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lymphatic System	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mental Status	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pulse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hearing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

(Please specify) : \_\_\_\_\_

**Health problems that need special attention, if any:**

---

---

**Laboratory findings**

Blood : Blood Sugar : \_\_\_\_\_ VDRL : \_\_\_\_\_  
: HBSAG : \_\_\_\_\_  
Chest film : \_\_\_\_\_ Date : \_\_\_\_\_

**Any evidence of infectious or contagious disease?**

Yes  (Please specify) \_\_\_\_\_  
No

**Elaborate on positive findings:**

\_\_\_\_\_  
\_\_\_\_\_

**Any further investigation or treatment required?**

Yes (Please specify, e.g. whether it is in need of special appliances)  
\_\_\_\_\_  
 No

**Does the applicant's present condition require inpatient-care in:**

	Yes	No
Hospital	<input type="checkbox"/>	<input type="checkbox"/>
Infirmery Care Unit	<input type="checkbox"/>	<input type="checkbox"/>

Date Examined: \_\_\_\_\_  
Name of Medical Practitioner: \_\_\_\_\_ Signed : \_\_\_\_\_  
Name of Hospital / Clinic : \_\_\_\_\_



### Data Updating Form

From: _____ <i>(Name of Referring Office)</i>	To: Central Referral System for Rehabilitation Services Subsystem for the Aged Blind (CRSRehab-AB) 9/F, Wu Chung House 213 Queen's Road East Wanchai, Hong Kong
_____	
Ref.: _____	Tel.: 2892 5136
Tel.: _____	Fax: 2893 6983
Fax: _____	
Date: _____	

Name: \_\_\_\_\_ HKID No.: \_\_\_\_\_ CRSRehab No.: \_\_\_\_\_

Information to be updated: ( ✓ or \* delete as appropriate)

- Placement is no longer required. Case can be deleted from CRSRehab-AB.
- 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.)  
Please specify : \_\_\_\_\_
- Change in location preference to : \_\_\_\_\_
- Others, please specify: \_\_\_\_\_

Signature: \_\_\_\_\_  
Name: \_\_\_\_\_  
Post: \_\_\_\_\_

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

**RESTRICTED****Removal from Waiting List**

From: Central Referral System for Rehabilitation Services  
 Subsystem for the Aged Blind (CRSRehab-AB)  
 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-AB 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 - AB  
 )

## Report of Vacancies

<p>From: _____ <i>(Name of Referring Office)</i></p> <p>_____</p> <p style="text-align: center;"><i>(Name of Organisation)</i></p> <p>Ref.: _____</p> <p>Tel.: _____</p> <p>Fax: _____</p> <p>Date: _____</p>	<p>To: Central Referral System for Rehabilitation Services Subsystem for the Aged Blind (CRSRehab-AB) 9/F., Wu Chung House 213 Queen's Road East Wanchai, Hong Kong</p> <p>Tel.: 2892 5136</p> <p>Fax: 2893 6983</p>
---	--

1. Number of vacancies as at \_\_\_\_\_ (date):

Service	C&A		Infirmery Unit	
	M	F	M	F
Sex				
(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-AB can send (a – b – c – d)				
Remarks				

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

Service	C&A		Infirmery Unit	
	M	F	M	F
Vacancies				
Available date(s)				
Remarks				

Signature: \_\_\_\_\_

Name: \_\_\_\_\_

Post: \_\_\_\_\_

**RESTRICTED****Selection for Placement**

From: Central Referral System for Rehabilitation Services  
 Subsystem for the Aged Blind (CRSRehab-AB)  
 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:

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-AB Form 7
2. CRSRehab-AB Form 2
3. Certification on blindness

(  
 Oi/c CRSRehab - AB  
 )

**RESTRICTED****Notification of Case Selection to Rehabilitation Unit**

From: Central Referral System for Rehabilitation Services  
 Subsystem for the Aged Blind (CRSRehab-AB)  
 Social Welfare Department  
 Room 901, 9/F Wu Chung House,  
 213 Queen's Road East, Wanchai, Hong Kong

To:

CRSRehab Tel.:  
 Fax:  
 Date:

Your Tel:  
 Your Fax:

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 above list, please contact the undersigned officer of the CRSRehab.

<u>Name</u>	<u>Gender/ Age</u>	<u>CRSRehab No.</u>	<u>Referring Office</u>	<u>Name of Referrer</u>	<u>Tel</u>	<u>Normal/ Priority</u>
-------------	------------------------	-------------------------	-------------------------	-------------------------	------------	-----------------------------

( )  
 Oi/c CRSRehab - AB

**RESTRICTED**

**Reply to CRSRehab-AB on Selection for Placement**

From: \_\_\_\_\_  
(Name of Referring Office)

\_\_\_\_\_  
(Name of Organisation)

Ref: \_\_\_\_\_

Tel: \_\_\_\_\_

Fax: \_\_\_\_\_

Date: \_\_\_\_\_

To: Central Referral System for Rehabilitation Services  
Subsystem for the Aged Blind (CRSRehab-AB)  
9/F, Wu Chung House  
213 Queen's Road East  
Wanchai, Hong Kong

Tel: 2892 5134

Fax: 2893 6983

**Application for placement to (name of rehabilitation 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 are attached:

- CRSRehab-AB Form 2                       Certification on blindness  
 Others: \_\_\_\_\_

**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.  
 Change of service type required due to improvement of ability. *Form 3* is attached to update placement request.  
 Change of service type required due to deterioration of ability. *Form 3* is attached to update placement request  
 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 the Aged Blind (CRSRehab-AB)  
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.:

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.

c.c. Agency Head

(  
Oi/c CRSRehab - AB  
)

**RESTRICTED****Referral for Admission**

From: Central Referral System for Rehabilitation Services  
 Subsystem for the Aged Blind (CRSRehab-AB)  
 Social Welfare Department  
 Room 901, 9/F Wu Chung House,  
 213 Queen's Road East, Wanchai, Hong Kong

To:

CRSRehab Tel.:  
 Fax:  
 Date:

Your Tel:  
 Your Fax:

**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. CRSRehab-AB Form 2
2. Certification on blindness

( Oi/c CRSRehab - AB )

c.c. Referring office (without enclosure):

Service Centre, (Fax no.: )

(case ref. )



**Report on Case Intake/Discharge**

From: \_\_\_\_\_  
*(Name of Rehabilitation Unit)*  
\_\_\_\_\_  
*(Name of Organisation)*  
Our Ref.: \_\_\_\_\_  
Tel.: \_\_\_\_\_  
Fax: \_\_\_\_\_  
Date: \_\_\_\_\_

To: Central Referral System for Rehabilitation Services  
Subsystem for the Aged Blind (CRSRehab-AB)  
9/F Wu Chung House  
213 Queen's Road East  
Wanchai, Hong Kong  
Your Ref.:  
Tel.: 2892 5136  
Fax: 2893 6983

1. Case information

Name: \_\_\_\_\_ HKID No.: \_\_\_\_\_ CRSRehab-AB No.: \_\_\_\_\_

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

- admitted into service from \_\_\_\_\_ *(date)*.
  
- unable to be admitted into service as there is no vacancy.
  
- rejected upon case screening due to:
  - health condition does not meet the admission criteria, ( \_\_\_\_\_ )\*  unstable mental/emotional condition
  - is recommended.  severe behavioral problem (please specify):
  - acute health problem  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  applicant/family members do not disclose any reason
  - lost trace  others (please specify):
  
- 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. \_\_\_\_\_ )

\* please insert a service type



## Application for Priority Placement

<p>From: _____  <div style="text-align: center; font-size: small;">(Name of Referring Office)</div> <hr/> <div style="text-align: center; font-size: small;">(Name of Organisation)</div> </p> <p>Our Ref.: _____          Tel.: _____          Fax: _____          Date: _____</p>		<p>To: Central Referral System for Rehabilitation Services          Subsystem for the Aged Blind (CRSRehab-AB)          9/F Wu Chung House          213 Queen's Road East          Wanchai, Hong Kong</p> <p>Your Ref.: _____          Tel.: 2892 5136          Fax: 2893 6983</p>
---	--	--

---

**1. Case particulars**

Name: \_\_\_\_\_ Sex/D.O.B.: \_\_\_\_\_ HKID No.: \_\_\_\_\_

Address: \_\_\_\_\_ Tel.: \_\_\_\_\_

Disability: \_\_\_\_\_

Placement required: \_\_\_\_\_ CRSRehab-AB 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 organizations or DSWO/ ADSWO of SWD.

**RESTRICTED****Outcome of Application for Priority Placement**

From: Central Referral System for Rehabilitation Services  
 Subsystem for the Aged Blind (CRSRehab-AB)  
 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 - AB  
 )

**RESTRICTED**  
**Central Referral System for Rehabilitation Services**  
**Subsystem for Small Group Home for Mildly Mentally Handicapped Children**  
**(CRSRehab-SGHMMHC)**  
**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 Island
- 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: Physically disabled, please specify: \_\_\_\_\_  
 N: Not physically disabled
2. Spastic / cerebral palsy  A: Spastic  B: Cerebral palsy  N: Not spastic or cerebral palsy
3. Hearing  A: Deaf  B: Partially Impaired  N: Normal
4. Vision  A: Blind  B: Partially Impaired  N: Normal
5. Mental disability IQ score: \_\_\_\_\_  
Date of psychological assessment: \_\_\_\_\_ (dd) \_\_\_\_\_ (mm) \_\_\_\_\_ (yyyy)  
(please attached psychological report)
6. Mental illness  A: Mentally ill, diagnosis: \_\_\_\_\_  
 N: Normal
7. Speech  A: Speech disabled  N: Normal
8. Autism  A: Autism as assessed by psychiatrist  N: Normal
9. Down's Syndrome  A: Downs Syndrome  N: Not Downs Syndrome
10. Other Illness / disability \_\_\_\_\_

11. Mobility  A: Walk unaided  B: Walk with escort  C: Walk with rehabaid  
 D: Wheelchair bound  E: Bed ridden
12. 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
13. Public transport (Excluding taxi)  A: Manage without escort  B: Manage with escort  
 C: Cannot manage with escort
14. Medication
15. Treatment required  A: Occupational therapy  B: Physiotherapy  
 C: Others: \_\_\_\_\_
16. Rehabaid used  A: Wheelchair  B: Ambulator  C: Prosthesis / artificial legs  
 D: Calipers  E: Special boots  F: Hearing aid  
 G: Crutches  H: Tripod  I: Others: \_\_\_\_\_

**III. Location preference**

Residential placement

- Small group home for mildly mentally handicapped children (SGHMMHC)  
 Integrated Small group home for mildly mentally handicapped children (ISGHMMHC)  
 SGHMMHC + ISGHMMHC  
 No (**Waiting time can be much shorter** if applicant does not indicate location preference)  
 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.

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 Mildly Mentally Handicapped Children  
 Social Welfare Department  
 Room 901, 9/F Wu Chung House, 213 Queen's Road  
 East Wanchai, Hong Kong

To:

--

CRSRehab-SGHMMHC Tel.:  
 Fax:  
 Date:

Your Ref.:  
 Your Fax:

The following applicant has been registered in CRSRehab-SGHMMHC for rehabilitation service. I now return your original *Form 1*. Please kindly verify the following data, raise amendment and update any subsequent change to CRSRehab-SGHMMHC by *Form 3*. For case enquiries, please contact the staff-on-duty at . For data protection, only enquiries from the referrer will be answered.

**II. Personal Particulars**

Name (English):  
 Name (Chinese):  
 HKBC:

Sex:  
 Date of Birth:  
 Residential District:

**III. Disability**

Physical disability:  
 Hearing:  
 IQ score:  
 Mental Illness:  
 Autism:  
 Other disability:  
 Climb stairs/slope:  
 Treatment required:

Spastic/cerebral palsy:  
 Vision:  
 Date of assessment:  
 Speech:  
 Downs Syndrome:  
 Mobility:  
 Public transport:  
 Rehabaid used:

**IV. Placement Request**

Type of placement:  
 CRSRehab-SGHMMHC no.  
 Status of service:  
 Location preference:

Application date:

- 1.
- 2.
- 3.
- 4.
- 5.

**V. Status of applicant:**

Priority :

(  
 Oi/c CRSRehab - SGHMMHC  
 )

**限閱文件**  
**RESTRICTED**

社會福利署  
康復服務中央轉系統  
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 / 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)  
\_\_\_\_\_  
(Name of Organisation)  
\_\_\_\_\_  
(Address of Referring Office)

Ref.: \_\_\_\_\_

Tel.: \_\_\_\_\_

Fax: \_\_\_\_\_

Date: \_\_\_\_\_

To: Central Referral System for Rehabilitation Services  
Subsystem for Small Group Home for Mildly Mentally  
Handicapped Children  
Social Welfare Department  
9/F Wu Chung House  
213 Queen's Road East  
Wanchai, Hong Kong

Tel.: 2892 5134

Fax: 2893 6983

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-SGHMMHC.
- 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. \_\_\_\_\_
  4. \_\_\_\_\_
  5. \_\_\_\_\_

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 Small Group Home for Mildly Mentally Handicapped Children  
 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-SGH upon:  
Admitted to required service
- 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 - SGHMMHC  
 )

### Report of Vacancies

From: _____ _____ _____ _____ Ref.: _____ _____ Tel.: _____ Fax: _____ Date: _____	To: Central Referral System for Rehabilitation Services Subsystem for Small Group Home for Mildly Mentally Handicapped Children Social Welfare Department 9/F Wu Chung House 213 Queen's Road East Wanchai, Hong Kong  Tel.: 2892 5134 Fax: 2893 6983
--	--

1. Number of vacancies as at \_\_\_\_\_ (date):

Service	Residential	
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 referral(s) CRSRehab-SGHMMHC can send (a – b – c – d)		
Remarks		

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

Service	Residential	
Sex	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 Mildly Mentally Handicapped Children  
 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:

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-SGH Form 7
2. Psychological report (for MH)
3. Referral Form for Placement in Residential Child Care Services (CRSRC 3)

(  
 Oi/c CRSRehab - SGHMMHC  
 )

**RESTRICTED****Notification of Case Selection to Rehabilitation Unit**

From: Central Referral System for Rehabilitation Services  
 Subsystem for Small Group Home for Mildly Mentally Handicapped Children  
 Social Welfare Department  
 Room 901, 9/F Wu Chung House, 213 Queen's Road  
 East Wanchai, Hong Kong

To:

CRSRehab Tel.:  
 Fax:  
 Date:

Your Tel:  
 Your Fax:

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.

<u>Name</u>	<u>Gender/ Age</u>	<u>CRSRehab No.</u>	<u>Referring Office</u>	<u>Name of Referrer</u>	<u>Tel</u>	<u>Normal/ Priority</u>
-------------	------------------------	-------------------------	-------------------------	-----------------------------	------------	-----------------------------

( )  
 Oi/c CRSRehab - SGHMMHC

**RESTRICTED**

**Reply to CRSRehab-SGHMMHC on Selection for Placement**

From: _____ <i>(Name of Referring Office)</i>	To: Central Referral System for Rehabilitation Services Subsystem for Small Group Home for Mildly Mentally Handicapped Children 9/F, Wu Chung House 213 Queen's Road East Wanchai, Hong Kong
_____	
_____	
Ref.: _____	
Tel.: _____	
Fax: _____	Tel.: 2892 5134
Date: _____	Fax: 2893 6983

**Application for Admission to** *(name of rehabilitation 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 are attached:

- Psychological/psychiatric/medical \* report
- Referral Form for Placement in Residential Child Care Services (CRSRC 3)

**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).
- 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.
- Change of service type required due to improvement of ability. *Form 3* is attached to update placement request.
- Change of service type required due to deterioration of ability. *Form 3* is attached to update placement request.

Others, please specify: \_\_\_\_\_

**Applicant is temporarily hospitalised.**

Name of Hospital: \_\_\_\_\_  
Admission date: \_\_\_\_\_  
Diagnosis/Treatment required: \_\_\_\_\_

Signature: \_\_\_\_\_

Name: \_\_\_\_\_

Post: \_\_\_\_\_

\* Please delete as appropriate

c.c. Rehabilitation Unit ( )

**RESTRICTED****Reminder to Referrer**

From: Central Referral System for Rehabilitation Services  
 Subsystem for Small Group Home for Mildly Mentally Handicapped Children  
 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:

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 - SGHMMHC  
 )

c.c.

**RESTRICTED****Referral for Admission**

From: Central Referral System for Rehabilitation Services  
 Subsystem for Small Group Home for Mildly Mentally Handicapped Children  
 Social Welfare Department  
 Room 901, 9/F Wu Chung House, 213 Queen's Road East  
 Wanchai, Hong Kong

To:

--

CRSRehab Tel.:  
 Fax:  
 Date:

Your Tel:  
 Your Fax:

**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:	Travel Document:
Gender / D.O.B.:	CRSRehab No.:

**Referral papers attached:**

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

( Oi/c CRSRehab - SGHMMHC )

c.c. Referring office (without enclosure):



### 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 Small Group Home for Mildly Mentally  
Handicapped Children  
Social Welfare Department  
9/F Wu Chung House  
213 Queen's Road East  
Wanchai, Hong Kong  
  
Tel.: 2892 5134  
Fax: 2893 6983

#### 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:
- |   |   |
|---|---|
| <input type="checkbox"/> fail in job test   | <input type="checkbox"/> health problem (please specify):<br>_____              |
| <input type="checkbox"/> low ability/motivation for training  | <input type="checkbox"/> severely behavioral problem (please specify):<br>_____ |
| <input type="checkbox"/> unstable mental/emotional condition  | <input type="checkbox"/> others (please specify):<br>_____                      |
| <input type="checkbox"/> need of infirmary care<br>(Referrer to refer the case to Hospital<br>Authority for assessing the suitability for<br>infirmary service) |   |
- self-withdrawn by applicant upon case screening due to:
- |   |  |
|---|--|
| <input type="checkbox"/> open employment  | <input type="checkbox"/> prefer to live with/cared by family members |
| <input type="checkbox"/> unfavourable location                                  | <input type="checkbox"/> lost trace                                  |
| <input type="checkbox"/> applicant/family members do not disclose<br>any reason | <input type="checkbox"/> others (please specify):<br>_____           |
- discharged from our service on \_\_\_\_\_ (date) due to the following reason (relevant assessment report(s) is/are attached):

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 Mildly Mentally Handicapped Children  
 Social Welfare Department  
 Room 901, 9/F Wu Chung House, 213 Queen's Road East  
 Wanchai, Hong Kong

To:

--

CRSRehab Tel.:  
 Fax:  
 Date:

Your Tel:  
 Your Fax:

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 - SGHMMHC  
 )

c.c. Agency Head  
 Referrer:

**Application for Priority Placement**

From: _____ _____ _____ _____ Ref.: _____ Tel.: _____ Fax: _____ Date: _____	To: Central Referral System for Rehabilitation Services Subsystem for Small Group Home for Mildly Mentally Handicapped Children Social Welfare Department 9/F Wu Chung House 213 Queen's Road East Wanchai, Hong Kong  Tel.: 2892 5134 / 2892 5136 Fax: 2893 6983
(Name of Referring Office) (Name of Organization) (Address of Referring Office)	

**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).**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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

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

**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: \_\_\_\_\_

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

**Outcome of Application for Priority Placement**

From: Central Referral System for Rehabilitation Services  
Subsystem for Small Group Home for Mildly Mentally Handicapped Children  
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 - SGHMMHC  
)

**RESTRICTED**  
**Central Referral System for Rehabilitation Services**  
**Subsystem for the Supported Employment (SE) Service (CRSRehab-SE)**  
**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 6)**

1. Ex-mental ill  diagnosis: \_\_\_\_\_

2. Mental handicap  A: Severe  B: Moderate  
 C: Mild  D: Others, please specify diagnosis: \_\_\_\_\_

**Please also provide relevant information [(ii) 7] for selection of the above C or D.**

IQ score: \_\_\_\_\_ Mental age (in months): \_\_\_\_\_

Date of psychological assessment: \_\_\_\_\_ (dd) \_\_\_\_\_ (mm) \_\_\_\_\_ (yyyy)

3. Physical handicap  please specify: \_\_\_\_\_
4. Hearing impairment  A: Deaf  B: Partially impaired
5. Visual impairment  A: Blind  B: Partially impaired
6. Visceral disability  please specify: \_\_\_\_\_

**(ii) Other disability (Apart from the above 1 to 6, please specify if the applicant has other disability/disabilities)**

7. Other disability  N: No [Not applicable if the reply to Part IC(i)2 above is C or D]
- A: Others, please see the note below and specify: \_\_\_\_\_

*[Note : If the applicant has other disability or other diagnosis, please specify. If the reply to Part IC(i)2 above is C or D while the applicant has **no other disability**, please fill in "RECOMMENDED BY ALLIED HEALTH PROFESSIONAL" for applicant who can be benefitted from SE service as recommended by allied health professional **OR** "PENDING ASSESSMENT BY OPERATOR" for applicant pending assessment/recommendation of the SE service operator.]*

**(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-SE 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 SE 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 service; priority placement if required e.g. upward movement from sheltered workshop)

\_\_\_\_\_  
 \_\_\_\_\_

**RESTRICTED****Confirmation of Registration**

From: Central Referral System for Rehabilitation Services  
 Subsystem for the Supported Employment Service  
 Social Welfare Department  
 6/F, West Coast International Building, 290-296 Un Chau Street,  
 Sham Shui Po, Kowloon

To:

CRSRehab-SE Tel.:  
 Fax:  
 Date:

Your ref.:  
 Your Tel:  
 Your Fax:

The following applicant has been registered in CRSRehab-SE for supported employment service. Please kindly verify the following data and use *Form 3* to amend/update the information if needed. For case enquiries, please contact the undersigned at 2892 5344. For protection of private data, only enquiries from the referrers will be answered.

**I. Personal Particulars**

Name (English):

HKIC:

Date of Birth:

Sex:

Residential District:

**II. Disability**

Ex-mental ill:

Mentally Handicapped:

Mental Age:

IQ Score:

Date of Assessment:

Spastic/cerebral palsy:

Epilepsy:

Mobility:

Climb Stair/Slope:

Medication:

Public transport:

Treatment required:

Rehabaid used:

Physical handicap:

Hearing Impairment:

Visual Impairment:

Visceral disability:

Other disability:

**III. Placement Request**

Type of placement:

CRSRehab no.

Location preference:

Application date:

Waiting List:

( )

Oi/c CRSRehab-SE

**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: _____ <i>(Name of Referring Office)</i>	To: Central Referral System for Rehabilitation Services Subsystem for the Supported Employment Service Social Welfare Department 6/F, West Coast International Building 290-296 Un Chau Street Sham Shui Po Kowloon
_____	
_____	
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-SE.
- 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 Service  
 Social Welfare Department  
 6/F, West Coast International Building, 290-296 Un Chau Street,  
 Sham Shui Po, Kowloon

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-SE 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-SE  
 )

## Report of Vacancies

From: _____ <i>(Name of Rehabilitation Unit)</i> _____ <i>(Name of Organisation)</i> _____ <i>(Address of Rehabilitation Unit)</i>	To: Central Referral System for Rehabilitation Services Subsystem for the Supported Employment Service Social Welfare Department 6/F, West Coast International Building 290-296 Un Chau Street Sham Shui Po Kowloon
Ref.: _____ _____ Tel.: _____ Fax: _____ Date: _____	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-SE 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 Service  
Social Welfare Department  
6/F, West Coast International Building, 290-296 Un Chau Street,  
Sham Shui Po, Kowloon

To:

CRSRehab Tel.:  
Fax:  
Date:

Your Ref.:  
Your Tel.:  
Your Fax:

The following applicant has been selected for placement in a supported employment service 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 service 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 service unit directly:

1. Form 1
2. Form 7
3. Medical report (for Ex-MI, MH, PH, HI, VI and VD)

( Oi/c CRSRehab-SE )





**RESTRICTED**

**Reply to CRSRehab-SE on Selection for Placement**

From: _____ (Name of Referring Office) _____ (Name of Organisation) _____ (Address of Referring Office)	To: Central Referral System for Rehabilitation Services Subsystem for the Supported Employment Service Social Welfare Department 6/F, West Coast International Building 290-296 Un Chau Street Sham Shui Po Kowloon
Ref.: _____	
Tel.: _____	
Fax: _____	Tel.: 3586 3952
Date: _____	Fax: 3755 4946

**Application for Admission to** (name of supported employment service 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 service unit.:

- |   |   |
|---|---|
| <input type="checkbox"/> CRSRehab-SE Form 1                 | <input type="checkbox"/> School progress/VTC * report |
| <input type="checkbox"/> Psychological/psychiatric * report | <input type="checkbox"/> Medical report               |
| <input type="checkbox"/> Others, please specify: _____      |   |

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

- Applicant considers the location of supported employment service 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 Service  
 Social Welfare Department  
 6/F, West Coast International Building, 290-296 Un Chau Street,  
 Sham Shui Po, Kowloon

To:

CRSRehab-SE Tel.:  
 Fax:  
 Date:

Your Ref.:  
 Your Fax:

Name of applicant:

HKIC No.:

CRSRehab No.:

Date of Selection :

Name of SE Unit :

---

CRSRehab-SE has not received your reply to the placement offer for the above-named applicant. I would be grateful if you would reply to CRSRehab-SE 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-SE.

( )

Oi/c CRSRehab-SE

c.c. ADSWO( ) (for SWD Staff)  
 Agency Head (for NGO Staff)



## Report on Case Intake/Discharge

From: _____ <i>(Name of Rehabilitation Unit)</i> _____ <i>(Name of Organisation)</i> _____ <i>(Address of Rehabilitation Unit)</i>	To: Central Referral System for Rehabilitation Services Subsystem for the Supported Employment Service Social Welfare Department 6/F, West Coast International Building 290-296 Un Chau Street Sham Shui Po Kowloon
Ref.: _____	
Tel.: _____	
Fax: _____	Tel.: 3586 3952
Date: _____	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:
- |  |  |
|--|--|
| <input type="checkbox"/> fail in job test                    | <input type="checkbox"/> unstable mental/emotional condition         |
| <input type="checkbox"/> low ability/motivation for training | <input type="checkbox"/> severe behavioral problem (please specify): |
| <input type="checkbox"/> health problem                      | <input type="checkbox"/> others (please specify):                    |
- self-withdrawn by applicant upon case screening due to:
- |  |   |
|--|---|
| <input type="checkbox"/> open employment       | <input type="checkbox"/> applicant do not disclose any reason |
| <input type="checkbox"/> unfavourable location | <input type="checkbox"/> others (please specify): _____       |
| <input type="checkbox"/> lost trace            |   |
- discharged from our service on \_\_\_\_\_ (dd/mm/yyyy) due to:
- |   |
|---|
| <input type="checkbox"/> successfully discharge (i.e meeting the criteria of FSA) |
| <input type="checkbox"/> unsuccessful discharge on ____, please specify reason:   |
| <input type="checkbox"/> 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 Service  
 Social Welfare Department  
 6/F, West Coast International Building, 290-296 Un Chau Street,  
 Sham Shui Po, Kowloon

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 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 ReferralCRSRehab No. Name of ApplicantSexAge

( Oi/c CRSRehab-SE )

c.c. Agency Head  
 Referrer:



## Outcome of Application for Priority Placement

From: Central Referral System for Rehabilitation Services  
 Subsystem for the Supported Employment Service  
 Social Welfare Department  
 6/F, West Coast International Building, 290-296 Un Chau Street,  
 Sham Shui Po, Kowloon

To:

Your Ref.:  
 Date:

CRSRehab Tel.:  
 Fax:

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 undersigned for discussion on the case.

( \_\_\_\_\_ )  
 Oi/c CRSRehab-SE

**RESTRICTED**

**Day/Residential Service for Mentally or Physically Handicapped Persons**  
**Medical Examination Form**

**Personal Data of Applicant**

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

Sex/Age/D.O.B.: \_\_\_\_\_ HKIC No.: \_\_\_\_\_ Tel.: \_\_\_\_\_

**Major Diagnosis**

Mentally Handicapped     Mild     Moderate     Severe     Profound

Physically Handicapped    Please specify: \_\_\_\_\_

Psychiatric Illness    Please specify: \_\_\_\_\_

**Medical History**

	<u>No</u>	<u>Yes</u>	If yes, please elaborate:
Symptoms of Infectious Diseases e.g. diarrhoea, rash, frequent cough, past chest infection, etc.	<input type="checkbox"/>	<input type="checkbox"/>	_____
Allergy to Food or Drug	<input type="checkbox"/>	<input type="checkbox"/>	_____
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	mild (once a month) _____ moderate (once a week) _____ severe (once a day) _____
Swallowing Difficulties/Easy Choking	<input type="checkbox"/>	<input type="checkbox"/>	_____
Recent Auditory/Visual Deterioration	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other Significant Illness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Recent Travelling (within past 6 months)	<input type="checkbox"/>	<input type="checkbox"/>	_____

**Physical Examination**

General Condition                      Satisfactory                      Fair                      Poor  
           

	<u>Normal</u>	<u>Abnormal</u>	If abnormal, please elaborate:
Skin Condition, e.g. scabies, jaundice	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lymphatic System	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dental Condition	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chest	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cardiovascular System	<input type="checkbox"/>	<input type="checkbox"/>	_____
Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	_____
Limbs, Spine	<input type="checkbox"/>	<input type="checkbox"/>	_____
Possible Signs of Infectious Diseases	<input type="checkbox"/>	<input type="checkbox"/>	_____

Other Findings: \_\_\_\_\_

BP: \_\_\_\_\_ mmHg



**RESTRICTED**

**Special Examination**

Urine: \_\_\_\_\_ Glucose: \_\_\_\_\_ Albumin: \_\_\_\_\_

Stool ova/cyst: (if not done within past 3 months) \_\_\_\_\_

Blood: Hb: \_\_\_\_\_ gm/dl. WBC: \_\_\_\_\_ /cu.mm. Plat: \_\_\_\_\_ /cu.m.

HBs Ag (if not vaccinated): \_\_\_\_\_

Liver function: \_\_\_\_\_ Renal function: \_\_\_\_\_

Reason(s) if blood test is not done:  doctor considers not clinically indicated for the test  
 parents/guardian refuse  client is uncooperative  
 Others: \_\_\_\_\_

CXR (if not done within past 3 months): \_\_\_\_\_

(If CXR may suggest TB, the case has been referred to chest clinic:  Yes  No

Others (please specify): \_\_\_\_\_

Current Treatment (specify dosage):

Name(s) of Treatment Providers (e.g. clinic):


Previous Operations

Dates


Need for Special Diet  No  Yes, please specify: \_\_\_\_\_

**Doctor's Recommendations:**

1. The applicant is  fit /  unfit for admission to day/residential 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.

**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 total **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 visual impairment \*:**

	<u>Right Eye</u>	<u>Left Eye</u>
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 <sup>#</sup>	
	Worse than:	Equal to or better than:
Blindness	• 3/60	• No light perception
Severe vision impairment	• 6/60	• 3/60
	People with <u>constricted</u> vision field in which the widest field diameter subtends an angular subtense of <u>20 degrees or less</u> , irrespective of visual acuity	
Moderate vision impairment	• 6/18	• 6/60
Mild vision impairment	• 6/12	• 6/18

<sup>#</sup> Visual acuity refers to the visual acuity of the better eye with correcting devices.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Doctor's full name: \_\_\_\_\_

Chop of  
Hospital / Clinic:

\_\_\_\_\_

### Summary of Procedures on Central Referral System for Rehabilitation Services

Subsystem	Services Types	Maximum No. & Particulars of Preference	No. of Offer	Rejection by Agency	Hospitalisation of Applicant	
Subsystem for Small Group Home for Mildly Mentally Handicapped Children	Small Group Home for Mildly Mentally Handicapped Children/Integrated Small Group Home	5 preferences by region/district/centre	An offer will be made according to the indicated preference of the applicant. If an applicant declines the offer, his/her name will be removed from the waiting list (for exceptions, please refer to para. 2.22). He/She may make a fresh application if he/she is still in need of the service. For applicant of residential rehabilitation service under CRSRehab-MPH, he/she may request to transfer his/her application to the AWL and retain the date of application if he/she is not yet ready to accept the offer (please refer to para. 2.12 to 2.17 for details).	If applicant is rejected twice by different agencies for the same service, the referrer is required to reassess the type of service appropriate to the applicant.	<p>(a) For an ex-mentally ill applicant who is admitted to a mental hospital or psychiatric ward of a general hospital while being offered a placement, his name will be removed from the waiting list. A fresh application is required if he/she is still in need of the service.</p> <p>(b) For an applicant admitted to a general hospital while being offered a placement (except residential placement under CRSRehab-MPH), his/her name will be retained on the list for 3 months, which may be extended to 6 months in exceptional circumstances.</p> <p>(c) For an applicant admitted to a general hospital while being offered a residential placement under CRSRehab-MPH and is unlikely to be discharged shortly, the referrer should notify CRSRehab-MPH and his/her application would be transferred to the IWL temporarily. Upon his/her discharge, the referrer has to reassess his/her service needs and to reactivate his/her application with relevant forms to CRSRehab-MPH as appropriate according to para. 2.27.</p>	
Subsystem for the Mentally/Physically Handicapped	Supported Hostel, Hostels for Mentally / Physically Handicapped Persons, Care & Attention Home for Severely Disabled Persons					3 preferences by region/district/centre
	Sheltered Workshop, Day Activity Centre, Integrated Vocational Rehabilitation Services Centre	3 preferences by region/district/centre				
Subsystem for the Ex-Mentally Ill	Sheltered Workshop					3 preferences by region/district/centre
	Supported Hostel					
	Halfway House		3 preferences by region/district/centre			
	Long Stay Care Home	3 preferences by region/district/centre				
Subsystem for the Aged Blind	Care & Attention Home for the Aged Blind			3 preferences by region/district/centre		

**Notes of Application for Rehabilitation Services**  
**Applicable to Central Referral System for Rehabilitation Services –**  
**Subsystem for the Mentally/Physically Handicapped (CRSRehab-MPH)**

1. An applicant will receive the confirmation of application for rehabilitation service (Form 1B) and Notification of Assessment Result issued by the Central Referral System for Rehabilitation Services - Subsystem for the Mentally/Physically Handicapped (CRSRehab-MPH) from the referring caseworker.
2. An applicant who indicates no preference in location will be given a day placement in his/her residential district whereas residential rehabilitation services placement will be arranged to any service unit with vacancy on random basis.
3. An applicant who has no preference in location will wait shorter than those who indicate preference. However, in case there is a genuine need, the applicant may indicate preference by region(s)/district(s)/service unit(s).
4. Change of location preference will not affect the application date as long as the applicant has not been offered the required service.
5. An applicant can apply for transferring his/her application from the active to the inactive waiting list once for residential rehabilitation service if he/she is not ready for admission at the current stage. This will not affect his/her application date but the applicant would not be offered any placement as long as he/she is on the inactive waiting list. His/her application would be reactivated when the referrer confirms the need for reactivation upon assessment.
6. Except under the following circumstances, the application will be removed from the waiting list when the applicant declines a placement offer:
  - a) the placement is not offered in accordance with the applicant's indicated preference;
  - b) the applicant declines the placement offer (except residential or paired-up day and residential placement under CRSRehab-MPH) due to hospitalisation of not exceeding 3 months (except for ex-mentally ill persons admitted into psychiatric beds/hospitals);
  - c) the applicant declines a single day placement while he/she awaits for a residential placement;
  - d) the applicant for residential or paired-up day and residential services requests to be transferred to the inactive waiting list under CRSRehab-MPH
7. 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 residential 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.

---

After explanation by the Caseworker, I, \_\_\_\_\_, the applicant/family member(s)/guardian/carer(s)\* of \_\_\_\_\_, understand the content of the "Notes of Application for Rehabilitation Services" and agree to be waitlisted for the service(s) in accordance with the rules and regulations therein. I hereby give my consent to CRSRehab for releasing the personal information of the applicant to relevant Departments/Non-Governmental Organizations for processing of the application.

Signature: \_\_\_\_\_

(Applicant/Family Member(s)/Guardian/Carer(s))

\_\_\_\_\_  
(Name of Caseworker)

\_\_\_\_\_  
(Name of Agency)

\* Delete whichever is inapplicable

Date: \_\_\_\_\_

## 申請康復服務須知

康復服務中央轉介系統 - 弱智／肢體傷殘人士子系統 適用

- (一) 康復服務中央轉介系統 - 弱智／肢體傷殘人士子系統會透過轉介個案工作人員，向每一位申請人派發一份康復服務申請登記書（表格1B）及評估結果通知書。
- (二) 申請人在申請康復服務時如無指定任何區域／地區／中心，康復服務中央轉介系統將按申請人居住的地區作出日間服務的編配，而住宿服務的申請則會被電腦隨機編配往有空缺的中心。
- (三) 在一般的情況下，申請人如沒有指定的區域／地區／中心，其輪候的時間會較有選擇的申請為短。倘若有實際需要，申請人可以指定選擇服務區域／地區／中心。
- (四) 申請人在未被安排所需的服務前，可隨時更改其區域／地區／中心的選擇。是項更改，將不會影響其在輪候冊上的申請日期。
- (五) 如果申請人目前並未作好接受住宿服務的準備，可透過轉介社工提出將他／她的申請暫時轉至「非活躍」輪候冊。這樣將不會影響其在輪候冊上的申請日期，但暫時申請人並不會獲編配任何宿位。日後申請人可按實際需要，透過轉介社工提出將他／她的申請轉回「活躍」輪候冊上。
- (六) 如申請人不接受所編配之日間或日間及住宿服務，除以下情況外，則該項申請會在輪候冊上被刪除：
  - a) 獲編配之日間或日間及住宿服務並非申請人所指定的選擇；
  - b) 申請人獲編配服務時入住醫院接受不超過三個月之治療（申請弱智／肢體傷殘人士子系統中住宿／日間及住宿照顧服務和精神病康復者入住精神科病床／醫院除外）；
  - c) 沒有接受編配往純日間服務的日間及住宿服務申請人。
  - d) 申請弱智／肢體傷殘人士子系統中住宿／日間及住宿照顧服務的申請人要求轉往「非活躍」輪候冊。
- (七) 就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。

---

本人\_\_\_\_\_，為\*申請人／\_\_\_\_\_的家屬／監護人／照顧者\*，經個案工作人員解釋《申請康復服務須知》後，已明白有關內容，並願意根據所列之細則輪候服務。本人同意康復服務中央轉介系統將申請人的資料轉往提供服務的政府部門／非政府機構，以便處理有關的申請。

簽署：

\_\_\_\_\_  
(服務申請人／家屬／監護人／照顧者)

\_\_\_\_\_  
(個案工作人員姓名)

\_\_\_\_\_  
(服務機構)

\* 刪去不適用者

日期：

**Notes of Application for Rehabilitation Services**  
**Applicable to Central Referral System for Rehabilitation Services –**  
**Subsystems for the Aged Blind (CRSRehab-AB) / Ex-mentally Ill (CRSRehab-ExMI)/**  
**Small Group Home for Mildly Mentally Handicapped Children (CRSRehab-SGHMMHC)**

1. An applicant will receive the “Notification of Registration for Rehabilitation Services” (*Form 1B*) issued by CRSRehab-AB/ CRSRehab-ExMI/ CRSRehab-SGHMMHC/ from the referring caseworker.
2. An applicant who indicates no location preference will be allocated the placement to any service unit with vacancy on random basis.
3. The waiting time for offering a placement to an applicant who has no location preference will be shorter than those with location preference. However, in case there is a genuine need, the applicant may indicate preference by region(s)/district(s)/service unit(s).
4. Change of location preference can be requested at any time and will not affect the application date as long as the applicant has not been offered the required service.
5. An application will be removed from the waiting list when the applicant declines a placement offer unless the placement was not offered in accordance with the applicant’s indicated preference; or due to hospitalisation of not exceeding 3 months (Not applicable to CRSRehab-ExMI applicants who are admitted into psychiatric wards/hospitals).
6. Social Welfare Department (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 rehabilitation 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.

---

After explanation by the Caseworker, I, \_\_\_\_\_, the \* applicant/ family member/ guardian/ carer of \_\_\_\_\_, understand the content of the “Notes of Application for Rehabilitation Services” and agree to be waitlisted for the service(s) in accordance with the rules and regulations therein. I hereby give my consent to CRSRehab for releasing the personal information of the applicant to relevant Departments/ Non-Governmental Organisations for processing of the application.

Signature : \_\_\_\_\_  
(\*Applicant/Family Member/Guardian/Carer)

\_\_\_\_\_  
(Name of Caseworker)

\_\_\_\_\_  
(Name of Agency)

Date : \_\_\_\_\_

\* Delete whichever is inapplicable

Central Referral System for Rehabilitation Services  
Social Welfare Department

## 申請康復服務須知

康復服務中央轉介系統 - 視障老人服務子系統／  
康復服務中央轉介系統 - 精神病康復者服務子系統／  
康復服務中央轉介系統 - 輕度弱智兒童之家服務子系統 適用

- (一) 申請人會透過轉介個案工作員收到由康復服務中央轉介系統發出的《申請康復服務登記書》(表格1B)。
- (二) 申請人在申請康復服務時如無指定任何區域／地區／中心，康復服務中央轉介系統將會隨機編配申請人往有空缺的服務單位。
- (三) 申請人如沒有選擇指定的區域／地區／中心，其輪候時間會較有選擇的申請為短。倘若有實際需要，申請人仍可以選擇指定所需服務之區域／地區／中心。
- (四) 申請人在未被安排所需的服務前，可隨時更改其區域／地區／中心的選擇。是項更改，將不會影響其在輪候冊上的申請日期。
- (五) 如申請人不接受所編配之服務，則該項申請會在輪候冊上被刪除。唯獲編配之服務並非申請人所指定的選擇，或在獲編配服務時入住醫院接受不超過三個月之治療（不適用於康復服務中央轉介系統 - 精神病康復者服務子系統的申請人入住精神科病床／醫院）除外。
- (六) 就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。

---

本人\_\_\_\_\_，為 \*申請人／\_\_\_\_\_的  
\*家屬／監護人／照顧者，經個案工作員解釋《申請康復服務須知》後，已明白有關內容，  
並願意根據所列之細則輪候服務。本人同意康復服務中央轉介系統將申請人的資料轉往提  
供服務的政府部門／非政府機構，以便處理有關的申請。

簽署： \_\_\_\_\_  
(\*服務申請人/家屬/監護人/照顧者)

\_\_\_\_\_  
(個案工作員姓名)

\_\_\_\_\_  
(服務機構)

日期： \_\_\_\_\_

\* 刪去不適用者

社會福利署  
康復服務中央轉介系統

**Notes of Application for Rehabilitation Services**  
**Applicable to Central Referral System for Rehabilitation Services –**  
**Subsystem for the Supported Employment (CRSRehab-SE)**

1. An applicant will receive the confirmation of application for rehabilitation service (Form 1B) issued by the Central Referral System for Rehabilitation Services - Subsystem for the Supported Employment (CRSRehab-SE) from the referring caseworker.
  2. An applicant who indicates no preference in location will be given a day placement in his/her residential district .
  3. An applicant who has no preference in location will wait shorter than those who indicate preference. However, in case there is a genuine need, the applicant may indicate preference by region(s)/district(s)/service unit(s).
  4. Change of location preference will not affect the application date as long as the applicant has not been offered the required service.
  5. Except under the following circumstances, the application will be removed from the waiting list when the applicant declines a placement offer:
    - a) the placement is not offered in accordance with the applicant’s indicated preference; and
    - b) the applicant declines the placement offer due to hospitalisation of not exceeding 3 months.
  6. 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 residential 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.
- 

After explanation by the Caseworker \_\_\_\_\_ (Name of Caseworker) of \_\_\_\_\_ (Name of Agency), I, \_\_\_\_\_, the applicant/family member(s)/guardian/carer(s)\* of \_\_\_\_\_, understand the content of the “Notes of Application for Rehabilitation Services” and agree to be waitlisted for the service(s) in accordance with the rules and regulations therein. I hereby give my consent to CRSRehab for releasing the personal information of the applicant to relevant Departments/Non-Governmental Organizations for processing of the application.

Signature: \_\_\_\_\_

(Applicant/Family Member(s)/Guardian/Carer(s))

\* Delete whichever is inapplicable

Date: \_\_\_\_\_



## 申請康復服務須知

### 康復服務中央轉介系統 - 輔助就業服務子系統適用

- (一) 康復服務中央轉介系統 - 輔助就業服務子系統會透過轉介個案工作人員，向每一位申請人派發一份康復服務申請登記書（表格1B）。
- (二) 申請人在申請服務時如無指定任何區域／地區／中心，康復服務中央轉介系統將按申請人居住的地區作出編配。
- (三) 在一般的情況下，申請人如沒有指定的區域／地區／中心，其輪候的時間會較有選擇的申請為短。倘若有實際需要，申請人可以指定選擇服務區域／地區／中心。
- (四) 申請人在未被安排所需的服務前，可隨時更改其區域／地區／中心的選擇。是項更改，將不會影響其在輪候冊上的申請日期。
- (五) 如申請人不接受所編配之服務，除以下情況外，則該項申請會在輪候冊上被刪除：
  - e) 獲編配之服務並非申請人所指定的選擇；及
  - f) 申請人獲編配服務時入住醫院接受不超過三個月之治療。
- (六) 就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。

---

本人\_\_\_\_\_，為\*申請人／\_\_\_\_\_的家屬／監護人／照顧者\*，  
經個案工作人員\_\_\_\_\_ (姓名) \_\_\_\_\_ (服務機構)解釋《申請康復  
服務須知》後，已明白有關內容，並願意根據所列之細則輪候服務。本人同意康復服務中央轉  
介系統將申請人的資料轉往提供服務的政府部門／非政府機構，以便處理有關的申請。

簽署： \_\_\_\_\_  
(申請人／家屬／監護人／照顧者)

日期： \_\_\_\_\_

\* 刪去不適用者

社會福利署  
康復服務中央轉介系統

**Information Paper on the “Validity”  
of an Intellectual Assessment Report**

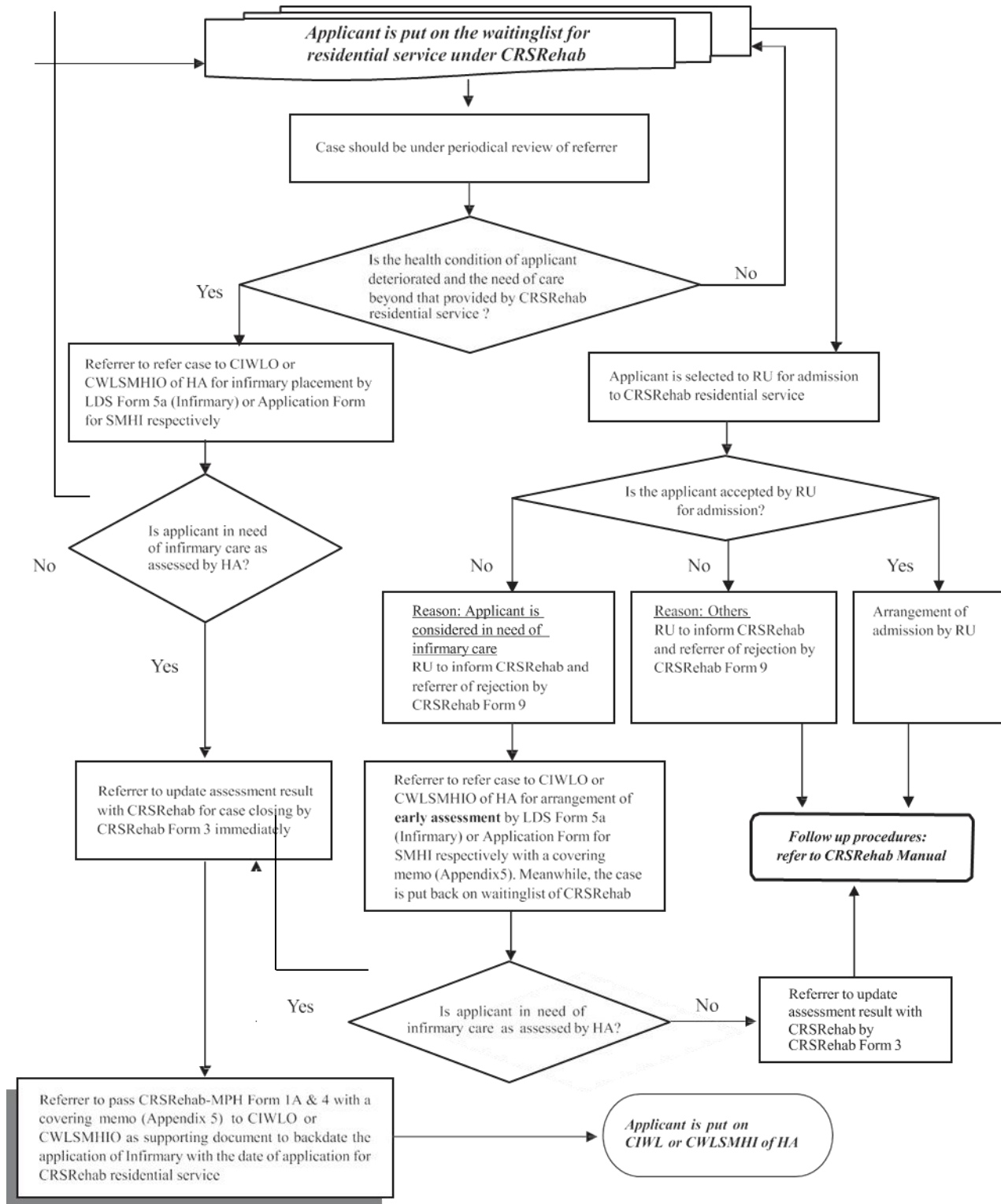
1. No “valid period” for intellectual assessment reports in general can be given, since time is neither a necessary factor nor the only factor that affects the functioning of a person. Each case has to be decided on an individual basis.
  
2. Intellectual assessment consists of assessment of both intellectual functioning and adaptive functioning. From a clinical psychologist’s point of view, the need for re-assessment of a client’s intellectual and adaptive functioning may be indicated under the following circumstances:
  - (i) If the client’s first assessment was conducted when he/she was at a very tender age, e.g. under six, it would be worthwhile, if necessary, for a re-assessment to be conducted in a few years’ time because the developments during childhood are vigorous and the abilities of the client could change quite a lot during this period. There can be a lot of changes between age 3 and age 6, but there might not be that much of a change between age 26 and age 36 or even age 46, although the time span in the latter is much longer.
  
  - (ii) If the client had been leading a deprived life when he/she underwent his/her first assessment, he/she may need a re-assessment after he/she has been given opportunity to learn and develop. For instance, new immigrants from mainland China might have lived in villages where there is little stimulation for development and opportunity to learn. Sometimes, they may even speak a dialect different from the local one. In that case, it might be advisable to re-assess the client after he/she has settled down in the local community for a few years.
  
  - (iii) Events have taken place after the first assessment, and there is reason to believe that such events have brought about some changes in the client. Examples of such events are a car accident which brings brain injury or a serious disease which leads to deterioration of a client’s abilities. In these situations, a re-assessment may be needed to find out the client’s current levels of intellectual functioning and adaptive functioning.
  
  - (iv) A client who is placed in a certain training centre is found to be unsuitable for it. For instance, a client who is placed in a day activity centre is found to be able to perform much better than the expected level, or a client who is placed in a sheltered workshop is found to be unable to adjust to the programmes there. In these situations, a re-assessment can be conducted to facilitate the allocation of more appropriate training programmes or placements.

3. In sum, a re-assessment is conducted only when there is a genuine need, not just to fulfill some administrative requirements. For instance, if a client has to be transferred from a day sheltered workshop to another sheltered workshop with residential service, he/she will be assessed with the SAT (Standardised Assessment Tool for Residential Services for People with Disabilities), which covers a series of factors associated with his/her residential service needs, instead of being evaluated for an updated severity of intellectual disability only. In this case, an updated assessment on the person's intellectual functioning and adaptive functioning is NOT necessary. Similarly, the Common Referral Form completed by special schools is much more comprehensive and informative than an intellectual assessment report for the purpose of evaluating a client's suitability for a post-school placement. To require intellectual assessment to be conducted again in spite of the rich information supplied by the special school is simply redundant, if not totally irrelevant.

4. Lastly, it is essential to note that an intellectual assessment is basically different from a school examination or test. While the latter is designed to test a person's competence or knowledge in specific areas, the former gives an estimate of a person's levels of general intellectual functioning and adaptive functioning. Additionally, while a person's knowledge or abilities in specific areas can vary from time to time and from subject to subject, a person's IQ, which represents his/her overall intellectual abilities and potentials, can remain quite constant over a long time under normal circumstances. Similarly, his/her overall adaptive functioning standard score, though less constant than IQ, is generally stable within a period of time if no special circumstances arise.

Clinical Psychological Service Branch Social Welfare Department  
15 July 2016

**Procedures for Change of Application from CRSRehab residential service to Infirmiry and Backdating Arrangement**



- CRSRehab: Central Referral System for Rehabilitation Services
- RU: Rehabilitation Unit
- HA: Hospital Authority
- CIWLO: Central Infirmiry Waiting List Office (Enquiry: 2300 6364)
- CIWL: Central Infirmiry Waiting List (for General Infirmiry)
- CWLSMHIO: Central Waiting List for SMH Infirmiry Office (Enquiry: 2300 6717)
- CWLSMHI: Central Waiting List for SMH Infirmiry (for severely mentally handicapped)

## Referral for Infirmarary Service

From : _____ (Name of Referrer)	To : Central Infirmarary Waiting List Office	Central Waiting List for SMH Infirmarary Office
_____	(Attn: SEM(MSD))	(Attn: EM(PS)6)
(Name of Referring Office)	Hospital Authority	Hospital Authority
_____	Room 515 S, Hospital	Room 514 S, Hospital
(Address of Referring Office)	Authority Building	Authority Building
Ref. : _____	147B Argyle Street,	147B Argyle Street,
Tel. : _____	Kowloon.	Kowloon.
Fax : _____	(for General Infirmarary)*	(for SMH Infirmarary)*
Date : _____	Tel.: 2300 6364	Tel.: 2300 6717
	Fax: 2881 5644	Fax: 2881 5848

## 1. Case information

Name: \_\_\_\_\_ HKIC No.: \_\_\_\_\_ CRSRehab No.: \_\_\_\_\_

## 2. Referral for assessment of need for infirmarary service/backdating application\*:

2.1  The above-named has been referred for admission to a Care and Attention Home for Severely Disabled Persons (C&A/SD) / Hostel for Severely Mentally Handicapped (HSMH) / Hostel for Moderately Mentally Handicapped (HMMH) / \_\_\_\_\_\*, but is considered to be in need of infirmarary service at the intake assessment. Hence, I would like to refer the case to you for an early assessment to confirm his/her\* suitability for infirmarary service. Attached please find the referral document:

- LDS Form 5a (Infirmarary) for General Infirmarary*
- Application Form for SMH Infirmarary*

2.2  The above-named is referred to you for backdating the application for infirmarary service as on. The case has already been closed at CRSRehab. Attached please find the **CRSRehab-MPH Form 1A and Form 4** as the supporting documents for your follow up action.

Signature: \_\_\_\_\_

Name: \_\_\_\_\_

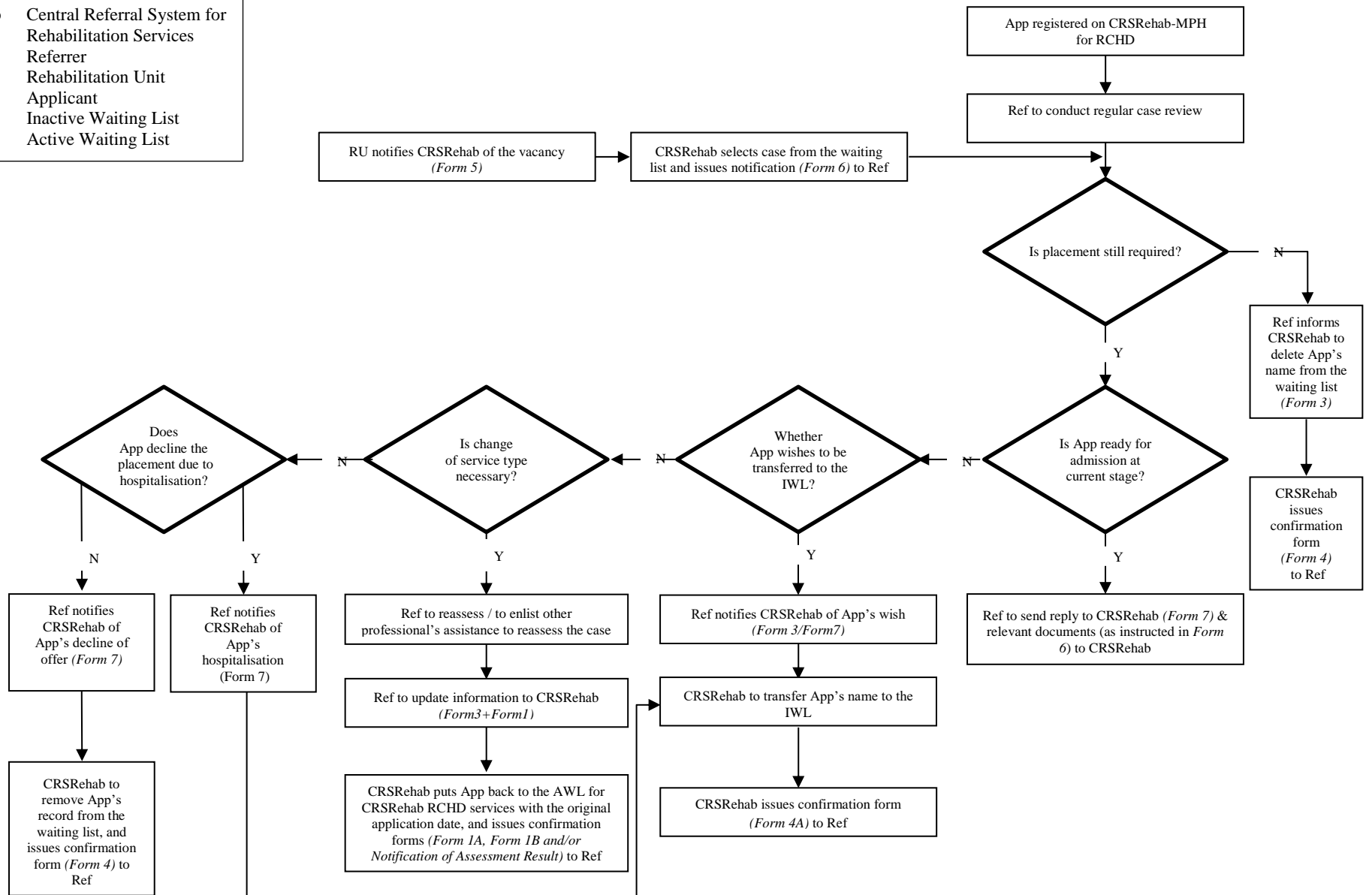
Post: \_\_\_\_\_

\* please delete as appropriate. For services other than these 3 services listed in the form, please fill in the blank with reference to paragraph 2.21.

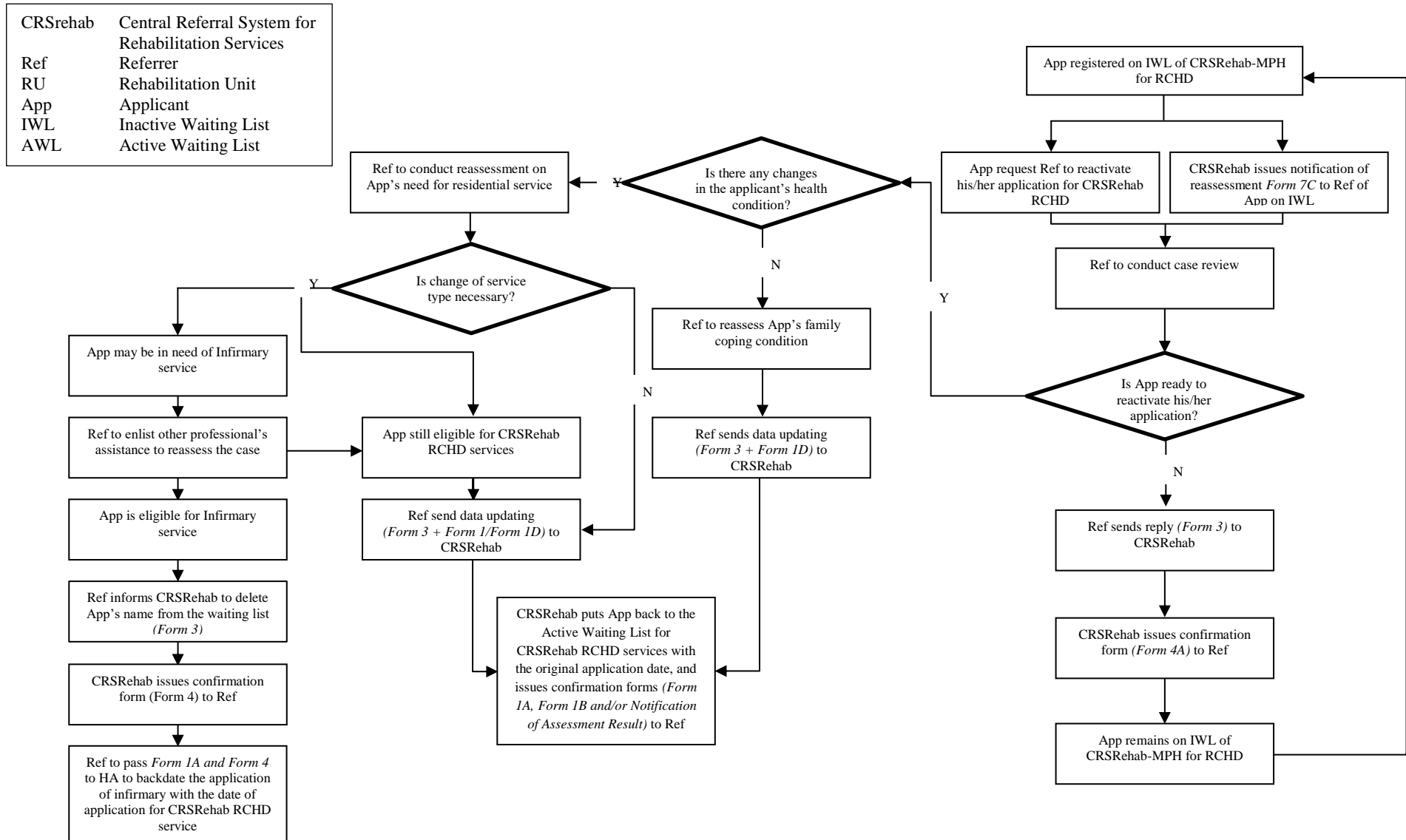
c.c. Oi/c CRSRehab-MPH (for 2.1 only) w/o encl.

### Transfer of cases to Inactive Waiting List under CRSRehab-MPH

CRSrehab	Central Referral System for Rehabilitation Services
Ref	Referrer
RU	Rehabilitation Unit
App	Applicant
IWL	Inactive Waiting List
AWL	Active Waiting List

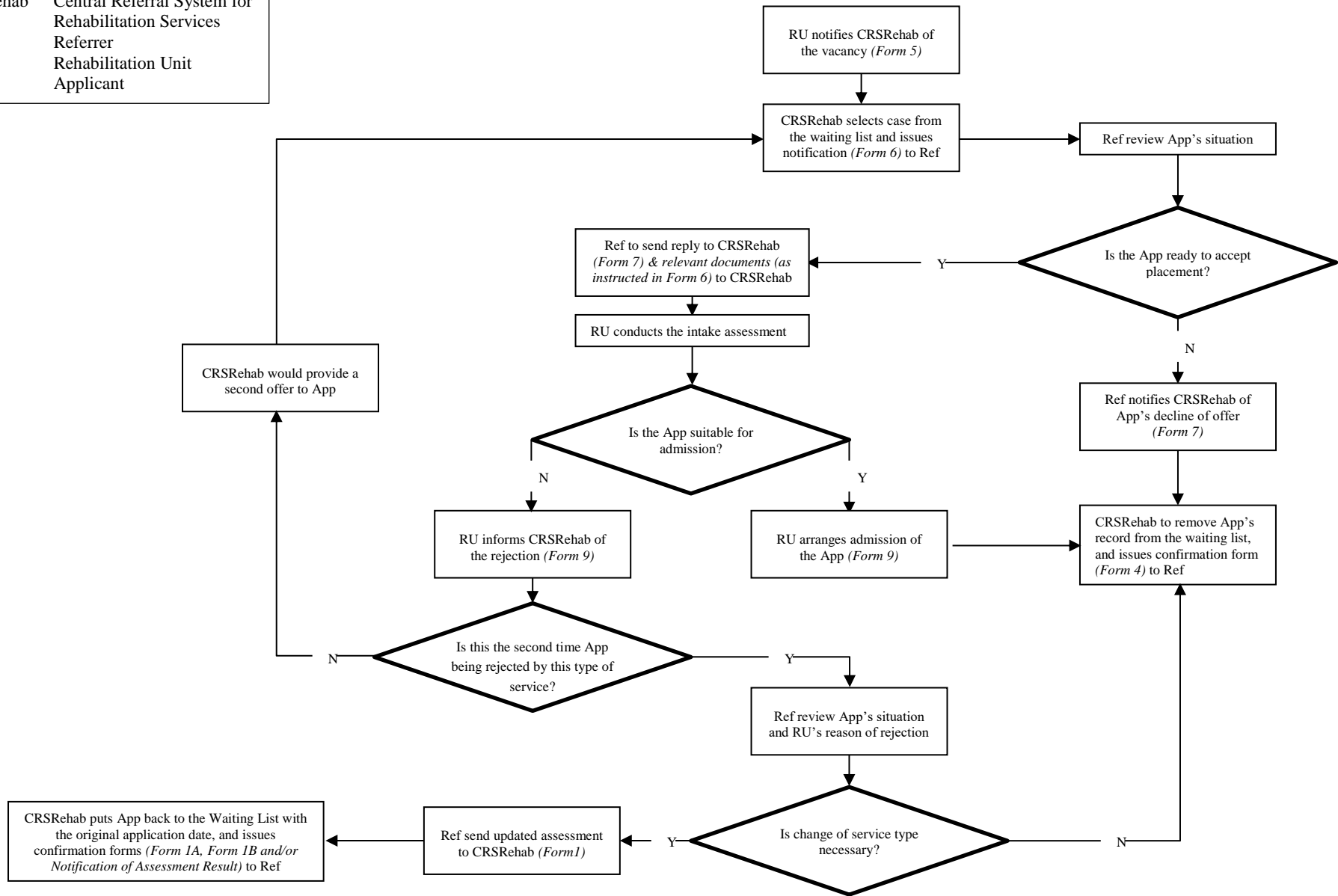


### Transfer of cases from Inactive Waiting List to Active Waiting List under CRSRehab-MPH



### Screening and Processing Admission to RCHD

CRSrehab	Central Referral System for Rehabilitation Services
Ref	Referrer
RU	Rehabilitation Unit
App	Applicant





Rehabilitation and Medical Social Services Branch  
Social Welfare Department  
September 2016 (Updated in March 2023)  
<http://www.swd.gov.hk>