**RESTRICTED**

Report on Case Intake / Discharge

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| From: |       |  |  | To: | Central Referral System for Rehabilitation ServicesSubsystem for the Ex-Mentally IllSocial Welfare DepartmentRoom 901, 9/F Wu Chung House213 Queen's Road East, Wanchai, Hong Kong |
|  | *(Name of Rehabilitation Unit)* |  |  |  |
|  |       |  |  |  |
|  | *(Name of Organisation)* |  |  |  |
| Our Ref.: |       |  |  |  |
| Tel.: |       |  |  | Your Ref.: |       |
| Fax: |       |  |  | Tel.: | 2892 5136 |
| Date: |       |  |  | Fax: | 2893 6983 |
|  |  |  |  |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Name of applicant: |  | HKIC No.: |  | CRSRehab No.: | D |
|  |  |  |  |
| Please be informed the above-named case has been: (✓ in the appropriate box) |
|  |  |  |  |
|  | **admitted** into service on |       | *(date)*. |
|  |  |
|  | **rejected** upon intake assessment due to: |
|  |  no vacancy |  unstable mental / emotional condition |
|  |  low ability / no motivation for training |  health problem |
|  |  severe behavioral problem (please specify): |  others (please specify): |
|  |         |
|  |  |
|  | **self-withdrawn** by applicant due to: |
|  |  unfavourable location |  refuse to attend pre-admission interview |
|  |  claim to have no day and / or residential service need  |  refuse to follow the regulation |
|  |  the family rejects the placement offer |  lost trace |
|  |  prefer to live with family / take care by family members |
|  |  open employment / supported employment ( for sheltered workshop applicant only) |
|  |  refuse to give reason |  |
|  |  others (please specify):        |
|  |  |
|  | **reserved** due to no immediate vacancy but would be admitted within 1 month.  |
|  | The admission is scheduled on  |       | *(date)* |
|  |  |
|  | **temporarily hospitalized**: (not applicable to the applicants who are admitted to psychiatric hospital or psychiatric ward of general hospital, please refer to CRSRehab Manual of Procedures): |
|  | Name of Hospital:  |       |
|  | Admission date: |       |
|  | Diagnosis / Treatment required: |       |
|  |  |  |
|  | **discharged** from our service on  |       | *(date)* due to: |       |
|  |       |

|  |  |
| --- | --- |
| Signature: |       |
| Name: |       |
| Post: |       |

c.c. Referring office