Application Form for Emergency Placement Service for Elders

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To : Sup	perintendent						
Fax No			(Nan	ne of Home)			
Date :							
rt I : Perso	nal Informo	ition					
(1) <u>Particulars (</u>	of applicant						
Name of applicat	nt:			()	Sex: M / F
HKIC No.:		Ag	ge:	Marita	l Status:		
Address:							
				Tel.:			
Religion:	Nati	ve Plac	e:	D	vialect Use	d:	
(2) <u>Particulars o</u>	of care-giver						
Name:	() Sex	:: M / F Rela	tionship: _		
Address:							
		Tel·		Mo	hila/Dagar		
		_ 101		1010	Une/rager	•	<u> </u>
	of family member						
(3) <u>Particulars</u>		s and 1	relative	s (please fill i	n if inforn If not liv	nation	is available)
(3) <u>Particulars</u>	of family member Relationship	s and 1	relative	s (please fill i	n if inforn If not liv	nation	<u>is available)</u> th applicant, give
(3) <u>Particulars</u>	of family member Relationship	s and 1	relative	s (please fill i	n if inforn If not liv	nation	<u>is available)</u> th applicant, give
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(3) <u>Particulars</u>	of family member Relationship with applicant	s and 1	relative	s (please fill i	n if inforn If not liv	nation	<u>is available)</u> th applicant, give

Name:	Relationship: Tel. No.:
Address:	
_	
(4) <u>Financia</u>	al status & income (Please ✓ appropriate items)
	On Comprehensive Social Security Assistance : -
_	(* Able-bodied or 50% disabled / 100% disabled / Requiring constant attendance)
	On Disability Allowance only : -
_	(* Normal Disability Allowance/ Higher Disability Allowance)
	On Old Age Allowance only
	Others (Please specify:)

Part II: Medical and Health Condition

(5) <u>Physical and mental condition</u> (Please ✓ appropriate items)

Any obvious disability and disfigurement (e.g. amputation, spastic, etc) (If yes, please specify)

Vision:	wearing glasses		Yes	No		
Sight:	adequate for self-c certified blind	are	Yes□ Yes□	No No		
Hearing for Normal	Communication:	Adequate	Inade	equate 🗖	Deaf	
Dental Condition:		Adequate	DPoor		Wearing der	nture
Incontinence:	Urine – Yes	No	Faeces –	- Yes	No	
Speech:	Adequate Speech Defect (Ple No speech	ease elaborate:)		
Mental Condition:	 Stable Confused Disturbing be Others (Please) 	haviour (Please	kious	2:)	_)

Mobility:

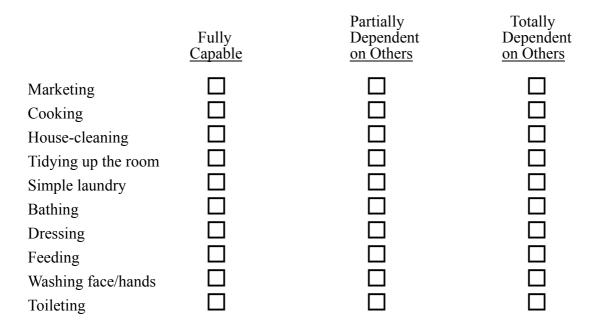
Self-ambulatory with walking aid or wheelchair

Always need personal escort

Bedridden

L Independent

(6) Activities of daily living



Part III : Application for Emergency Placement Service

	nergency placement se (appropriate item)	rvice applied and recommen	<u>ided</u>
Hom	e for the Aged	Care-and-Attention Home	□ Nursing Home
(8) <u>Period of</u>	emergency placement	service requested	
From		to	
(9) <u>Main rea</u>	son for application (Ple	ease \checkmark appropriate items and s	pecify where necessary)
	neless ction charged from hospital w ationship problem at exi	C	

Suspected elder abuse



Unforeseeable absence of care-givers Others (Please specify:

(10) <u>Remarks</u>

(Please put down any other relevant information worth drawing the attention of care-givers, e.g. significant events, risk factors, etc.)

_)

(11) <u>Referring Agency</u>					
Name of agency:					
Address:					
Reference No.:	Tel. No.: Fax No.:				
I shall be responsible for the welfare and discharge plan of the applicant being referred for emergency placement.					
Referring Social Worker	Countersigning Officer				
Signature :	Signature :				
Name :	Name :				
Post :	Post :				
Tel. No. :	Tel. No. :				
Date :	Date :				

The personal data collected will be used for the purpose of referral for an emergency placement in residential care home for the elderly or nursing home and may be disclosed to parties concerned on a need-to-know basis. The applicant may request access to and correction of their personal data, except when the data has been erased after fulfilling the purpose of collection and necessary retention period.