RESTRICTED

From: _____
(Name of Responsible Worker / Referring Worker)

_____
(Name of Office / Home)

Our Ref.: _____
Tel. No.: _____
Fax No.: _____
Date: _____

To: LDS Office

Tel No.
3620 3405

Fax No.
2891 6922
2838 9444

Application for Transfer of Resident to Infirmary Unit in C&A Home

(A) Name of Applicant: _____ Sex /Date of Birth : _____

HKID / COE No.: _____ LDS Serial No.: (if any) _____

Name of Home in which Applicant is residing: _____ (Subvented/EBPS)

Home Address: _____

Tel. No.: _____ CSSA No. (if applicable) : _____

(B) Name of Contact Person: (Mr/Mrs/Ms) _____

Address: _____

Tel. No.: _____ Relationship with Applicant: _____

I confirm that the above-named applicant *(pl. ✓ in the box as appropriate)*:

(i) has not currently been registered for the purpose of receiving Infirmary Care Supplement, and

(ii) ☐ has been assessed by the CGAT and waitlisted in HA for Infirmary Service, or

☐ has been assessed by CGAT to be not in need of infirmary service but assessed by accredited assessor/ SCNAMO(ES) with assessment result indicating service option as 'beyond nursing home'

Copies of documents attached *(pl. ✓ in the box as appropriate)*:

(i) ☐ LDS Form HA 12 'Result of Assessment by Community Geriatric Assessment Team', or

(ii) ☐ LDS Form HA 12 'Result of Assessment by Community Geriatric Assessment Team' and LDS Form 4 'Notification of Assessment Result'

Name of Responsible Worker / Referring Worker: _____

Signature: _____ Date: _____

Name of Supervisor / Superintendent: _____

Signature: _____ Date: _____

Confirmation of Registration for Transfer of Resident to Infirmary Unit in C&A Home

(to be completed by the LDS Office / Elderly Branch)

Registration No.: _____ Date of registration: _____