## Referral Form for Integrated Community Centre for Mental Wellness (ICCMW)

From: Officer-in-Charge	Te	o:	Officer-in-Charge
			TKO(S) ICCMW
Ref. :	R	ef.:	
Tel No. :	D	ated :	
Fax. No.:	F	ax. No. :	
Date:		total Page(s):	
Psychiatric Service of Hospita	Referral for I Services Unit / M al Authority (HA) alised Care Progr	ledical Socia / Communi	ty Psychiatric Services (CPS) /
Name :	Sex / Age	e:	Date of Birth:
Address:			
	CMW onuspected mental heal	and wo	(Name of referrer) of our Centre and uld like to refer the above-named for your sprovided:
Name : (English)		(Chin	ese)
Tel. No. : (Home)		– (Chin (Mol	ese) pile)
HKIC No.		_	
Service(s) required from ICCMW:	☐ Case managen ☐ Peer support se	ment	and Programmes  Skill training arer support linical psychological service
			ons in Mental Recovery
*Diagnosis / Suspected mental health	Others:		ons in Mental Recovery

Psychia	tric Follow-up	Clinic (if any	·):			
Special	Remarks:	Condition	onal Discharge	☐ Intensive Car	re	☐ Ex-intensive Care
		☐ Special	Care	Conventional	Care	
Contact	Points of Case I	Manager of *(	CPS/PCP (if any):	Name :		Tel. No. :
Other s	upport services	(e.g. MSSU,	POT, IFSC, etc.):			
	•		al or behavioral prodency and violence		•	attention, including but not
Rehabili	tation service(s)	waitlisted:	☐ Supported Emp ☐ Residential Ser ☐ Others: ☐ Not known	ployment rvice (please specif		ltered Workshop
*has been / social v	n / has not been n / has not been workers concern	obtained that ned for inforr	receiving ICCMW tICCMW's worker mation regarding the	can approach the ca provision of ICCM	ise medio IW servi	cal officer / paramedical staff ices.
(II) <u>Info</u>	rmation of Ap	olicant's Far	nily Member / Car	<u>eer</u>		
Name:	Mr./Mrs./Ms.		(	)	Tel. No.	:
	(English)		(Chine	se)		
Living w	vith the applican	t:*Yes/No	Relat	ionship with applica	ant :	

Consent of the family member / carer \*has been / has not been obtained that ICCMW's professional workers can approach \*him / her if necessary.

erral S	ummary and Special Remarks (Use additional sheet	if required)		
<u>matio</u>	of Referring Office			
eferrei	: Post :	Tel. No. :		
		Fax No. :		
ress:				
	Others (please specify):			
		g days from the date of this referral. For		
		(		
		Officer-in-Charge		
	Name of Centre:_			
	-			
	District:_			
	mation eferrer ress :	Our Centre will continue to follow-up the welfare nee Please issue the Service Admission Form to our unit referral.  No follow-up action will be taken by our Centre since other immediate and / or long term welfare needs at our Others (please specify):  ease acknowledge receipt of this referral within seven working ease contact at		

<sup>\*</sup>delete whichever is inappropriate