Caritas Family Crisis Support Center

Our Ref. : _____
Tel. No. : _____
Fax No. : _____
Total pages : _____

Date : _____

BY FAX (Fax No. 2383 2231)

To: Supervisor / Caritas Family Crisis Support Centre (FCSC)

Referral to Caritas Family Crisis Support Centre

Name : _____
HKID No. : _____
Sex / Age : _____

I refer to the telephone discussion between Mr/Miss/Ms/Mrs* _____ (N*ame of Social worker of Referring Centre*) and Mr/Miss/Ms/Mrs*_____ of your Centre on _____(*Date*). I should be grateful if you could admit the above-named for live-in service.

The following document(s) # is / are* attached for your information and necessary action:

☐ Intake report / Outreaching report (optional)
☐ Case Referral Form
☐ Others (please specify): _____

Remarks:

☐ The welfare need(s) of the above-named client is /will be followed up by Mr/Miss/Ms/Mrs*_____(N*ame of Social Worker of Referring Agency)*.
☐ Caseworker will be assigned within three working days from the date of this letter.
☐ The case will be referred to _____(Name of the follow-up agency/centre)
☐ Others (Please specify): _____

Please acknowledge receipt of this referral **within three working days** from the date of this letter. For enquiries, please contact Mr/Miss/Ms/Mrs* _____(*Name of Social Worker of Referring Centre*) at phone no. _____.

(_____)
Officer – in - charge

(_____)
Name of Referring Centre

* Please delete as appropriate.

Caritas Family Crisis Support Center

Case Referral Form

Tel：2383 2122 Referral Line：2383 4922 (For Referrer Only) Fax：2383 2231

Date：_____ Time：_____ Referring Agency：_____
Name of Referrer：_____ Tel： _____ Fax：_____
Our Reference No.：_____

Client's information：
Name (Chi)：_____ (Eng)：_____ I.D. No.: _____
Date of Birth：_____ *Sex：M / F Age：_____ Tel：_____
Address: _____

Information of Accompanying Person(s) (if applicable)

Name	Relationship	Sex / Age	Remarks (if any)

Presenting Problem and Reason for Referral:

_____

_____

Service Rendered:

_____

Follow-up Plan:

_____

Please tick as appropriate:

☐ Mental illness /Mental retardation / Physical disability / Chronic illness /Self-care problem / Adjustment problem to group living/infectious disease →

Medical Report is required to certify that client is fit for group living and self care

☐ None of the above problems

Financial status: ☐ Income ☐ Saving ☐ CSSA ☐ Others:_____ (please specify)

Service requested: ☐ live-in service ☐ Day program service ☐ Group service
☐ Others:_____ (please specify)

Urgency: ☐ Very urgent (Need to admit in few hours) ☐ Urgent (Need to admit within one day)

☐ Normal (Need to admit in few days) ☐ Not urgent (Whenever placement is available)