



## 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\* \_\_\_\_\_ (*Name 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\* \_\_\_\_\_ (*Name 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)