



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

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)