協青社 Youth Outreach

Crisis Residential Centre (Boys / Girls)
REFERRAL FORM

I. Client's Information

Name : (Chinese 中文)______________________ (English 英文)______________________

HKID No.______________________ Tel. No.______________________

Address :______________________

Correspondence Address:______________________

______________________ Tel. No.______________________

Date of birth :______Y______M______D Place of Birth :______________________

School / Employer :______________________ Tel. No.______________________

Name of Parent(s)/Guidance : ______________________ Tel. / Pager No.______________________

II. Reasons of running away from Home/Reasons of not living at Home :

III. Case Summary

(1) Family Background & Relationship

(2) Client's performance at school / work

(3) Client's emotional & behavioral characteristics

(4) Worker's Intervention

(5) Brief Case Development

(6) Medical History

		Yes	No	Unknown
1.	Is the client(C) or any family member(F) currently under observation or taking any treatment or medication?	C☐ F☐	C☐ F ☐	C☐ F☐
2.	Has the client or any family member had any operation, treatment, hospital care or medical examination before?	C☐ F☐	C☐ F ☐	C☐ F☐
3.	Has the client or any family member had any form of sexually transmitted disease or is there anything about his/her life style which could expose him/her to the risks of AIDS?	C☐ F☐	C☐ F ☐	C☐ F☐
4.	Has the client or any family member had the tendency of suicide or had attempted/committed suicide before?	C☐ F☐	C☐ F ☐	C☐ F☐
5.	Is the client or any family member suffering from any health (physical/psychological/psychiatric) problem?	C☐ F☐	C☐ F ☐	C☐ F☐
6(a).	Is the client or any family member having any drugs abuse behavior?	C☐ F☐	C☐ F ☐	C☐ F☐
6(b).	Is the client or any family member now still abusing drugs?	C☐ F☐	C☐ F ☐	C☐ F☐
7.	Is the client or any family member have any triad society background?	C☐ F☐	C☐ F ☐	C☐ F☐

Please provide details of each question answered "Yes".

Question No.	Name of Person treated	Details of Ailment	Duration Dates	Degree of Recovery	Name & Telephone of attending doctor

(7) Recommended Length of Stay in Youth Outreach

(8) Intervention Plan Suggested for Youth Outreach

(9) Remarks

IV. Referring Agency

Name of Agency :__________________

Name of Centre:___________________

Responsible Social Worker :_________

Tel / Pager No. :___________________

Signature :________________________

Date :_______Y_________M_______D

Countersigned by Supervisor :____________

Name:________________________________

Title :________________________________

Date :_________Y_________M_________D

For Offical Use Only

Date of entry : _______Y______M_______D Date of check-out : _____Y______M______D

Staff : ______________________________