協青社 Youth Outreach

Referral Form (個案轉介表)

Centre:

☐ Crisis Residential Centre - Boys' Centre (Fax: 2804 8627)

☐ Crisis Residential Centre - Girls' Centre (Fax: 2804 8629)

☐ Transitional Housing for Young Probationers and High-Risk Youth - Male Section (Fax: 2804 8626)

☐ Transitional Housing for Young Probationers and High-Risk Youth - Female Section (Fax: 2804 8632)

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. 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) Recommended Length of Stay in Youth Outreach

(7) Intervention Plan Suggested for Youth Outreach

(8) Is the client or any family member have any triad society background?

Client: ☐ Yes ☐ No ☐ Unknown

Family Member: ☐ Yes ☐ No ☐ Unknown

Please provide details if answered "Yes":

(9) Medical History

Please access whether the client or any family members have following medical condition:

		Client	Family members
1.	Currently under observation or taking treatment or medication.	Yes / No / Unknown	Yes / No / Unknown
2.	Operation, treatment, hospital care or medical examination history.	Yes / No / Unknown	Yes / No / Unknown
3.	Any form of sexually transmitted disease or anything about his/her life style which could expose him/her to the risks of AIDS.	Yes / No / Unknown	Yes / No / Unknown
4.	Tendency of suicide or history of attempted/committed suicide.	Yes / No / Unknown	Yes / No / Unknown
5.	Suffering from health problem. eg. physical/ psychological/ psychiatric	Yes / No / Unknown	Yes / No / Unknown
6.	Drugs abuse history or still abusing drugs.	Yes / No / Unknown	Yes / No / Unknown

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

(10) Remarks

IV. Referring Agency

Name of Agency and Centre : _____

Responsible Social Worker

Name :_____

Tel No. :_____

Signature :_____

Date :_____Y_____M_____D

Countersigned officer

Supervisor's Name:_____

Title :_____

Signature :_____

Date :_____Y_____M_____D