

Hong Kong Sheng Kung Hui Pilot Scheme on Multi-disciplinary
Outreaching Support Team for the Elderly (Kowloon Central Cluster)

Referral Form 《for Private Old Age Homes》

1. Name of Home : _____ (Referred to as “Home” below)
2. Name of Resident : _____ 3. HKID No : _____ ()
4. Gender : Male/ Female 5. Date of birth : _____ 6. Bed No. : _____
7. Mobile No. of Resident : _____ 8. Mobile No. of Family Member : _____ 9. Kinship : _____
10. Home Contact Person : _____ 11. Telephone No. : _____ 12. Fax : _____
13. Name of Referrer : _____ 14. Telephone No. : _____ 15. Fax : _____
16. Diagnosis of Resident : _____
17. Source of Referral (Please): Home Staff Resident Family Member of Resident
#Please circle the subordinate units Multi-disciplinary Outreaching Support Team for the Elderly (MOSTE) Staff
 Hospital Authority (HA) #: (CGAT / PGT / CNS / PT / OT / ST / MSW / Others : _____)
 Visiting Health Team/Elderly Health Service (DH)
 Visiting Medical Practitioner Service for Residential Care Homes (VMPS)
 Visiting Medical Officer (VMO) Other (please specify) : _____
18. Current services (Please): CGAT’s treatment or rehabilitation equipment purchasing services
 Geriatric Day Hospital (GDH) Palliative Care

19. Applying for Service(s) of :

| Service Type (Please <input checkbox"="" checked="" type="checkbox/>)</th> </tr> <tr> <th><input type="/> A. Physiotherapy | | | | <input type="checkbox"/> B. Occupational Therapy | <input type="checkbox"/> C. Speech Therapy | <input type="checkbox"/> D. Linkage Activity |
|--|--|---|--|--|--|--|
| Example : Pain Management, Mobility Training, Muscle strengthening, Aids consultation | Example : Cognitive/ ADL Training, Seating posture consultation, Assistive device (aids) consultation | Example : Swallowing/ Oral-motor training, Speech and Language Training, Consultation on diet modification, Feeding skill training for caregivers | Example : Social Activities, Concern Visit | | | |

20. Remarks : _____

21. Declaration of Resident / Family member

- I agree/ agree my _____ (kinship) _____ (resident’s name)* to accept the Multi-disciplinary Outreaching Support Service provided by the Hong Kong Sheng Kung Hui Welfare Council Limited (referred to as “Welfare Council” below).
- I delegate the Home to transfer and disclose the personal information of me/ my _____ (kinship) _____ (resident’s name)* (referred to as “Resident” below), including but not limited to the name, phone number, medical history and medication record, to the following parties on a need-to-know basis: 1) staff of relevant departments and units of the Welfare Council; 2) insurance companies, doctors and/ or other service providers appointed by the Welfare Council; 3) other medical staff involved in the caring of the Resident (including but not limited to doctors of Hospital Authority and Visiting Medical Practitioner Service for Residential Care Homes (VMPS)); and 4) government departments or organisations with authorization or statutory power to obtain such information.
- I understand my/ Resident’s personal information is provided to the Welfare Council on a voluntary basis. I also understand that I shall ensure the accuracy of all the personal data I supplied. In case there is any changes of the information, I shall notify the Welfare Council as soon as possible. I shall be responsible for any service delay, injuries or death caused by any inaccurate information provided.
- Except the circumstances specified under the Personal Data (Privacy) Ordinance, I understand that I have the right to apply for access to and/or correction of my/Resident’s personal data held by the Welfare Council. I shall submit application form and pay the handling fee when requesting for access to personal data or a photocopy of personal data. (* Please delete as appropriate. For mentally incapacitated elderly, Resident’s family members/ guardians may sign on his/her behalf and fill in the “kinship” column, for example: husband / wife / mother / father / elder brother / younger brother / elder sister / younger sister / guardian)

Resident/ Family member’s name : _____ Resident’s/ Family member’s signature : _____

Date : _____ Home/ Institution Chop : _____

To: _____ (Name of Home) Fax No./ Email Address : _____

Hong Kong Sheng Kung Hui Pilot Scheme on Multi-disciplinary
Outreaching Support Team for the Elderly (Kowloon Central Cluster)

Reply Slip 《Welfare Council Staff Only》

1. Our team has arranged the case manager _____ (Name) to your Home on ____ / ____ / ____ (DD/MM/YY) to follow up with the referral case of _____ (Resident's name).

2. After an assessment taken by our physiotherapist / occupational therapist / speech therapist / social worker, the result of application is as follows (please):

2.1 Our team is unable to provide physiotherapy / occupational therapy / speech therapy / Social work * services. Reasons : _____

2.2 Our team will provide physiotherapy / occupational therapy / speech therapy / social work * services. A brief summary is as follows :

2.2.1 General condition of the resident : _____

2.2.2 Follow-up plan (please):

| | <input type="checkbox"/> Physiotherapy | <input type="checkbox"/> Occupational Therapy | <input type="checkbox"/> Speech Therapy | <input type="checkbox"/> Linkage Activity |
|---------------------|---|---|--|--|
| Service Content | <input type="checkbox"/> Pain management <input type="checkbox"/> Balance training <input type="checkbox"/> Mobility training <input type="checkbox"/> Muscle strengthening <input type="checkbox"/> Joint mobilization <input type="checkbox"/> Aids prescription / consultation <input type="checkbox"/> Others : _____ | <input type="checkbox"/> Fine motor skill training <input type="checkbox"/> Maintain/ enhance the upper limb function training <input type="checkbox"/> Maintain/ enhance self-care ability <input type="checkbox"/> Maintain/ enhance ADL function <input type="checkbox"/> Maintain/ enhance cognitive function <input type="checkbox"/> Carer training <input type="checkbox"/> Sensory stimulation <input type="checkbox"/> Suggest suitable aids <input type="checkbox"/> Others : _____ | <input type="checkbox"/> Speech training <input type="checkbox"/> Language / communication training <input type="checkbox"/> Swallowing training <input type="checkbox"/> Oral-motor training <input type="checkbox"/> Saliva / oral hygiene management <input type="checkbox"/> Meal observation <input type="checkbox"/> Carer feeding training/ consultation <input type="checkbox"/> Diet modification <input type="checkbox"/> Others : _____ | <input type="checkbox"/> Various social activities <input type="checkbox"/> Leisure activities <input type="checkbox"/> Concern Visit <input type="checkbox"/> Others : _____ |
| Service arrangement | Provide weekly / monthly ____ sessions of physiotherapy services and reassess the service needs after ____ sessions. | Provide weekly / monthly ____ sessions of occupational services and reassess the service needs after ____ sessions. | Provide weekly / monthly ____ sessions of speech services and reassess the service needs after ____ sessions. | Provide _____ service/ activities and reassess the service needs after the activities. |

2.2.3 Remarks : _____

****Please delete if not applicable***

Case manager's name and signature : _____ Date : ____ / ____ / ____ (DD/MM/YY)

Supervisor's name and signature : _____ Date : ____ / ____ / ____ (DD/MM/YY)