To：Case Manager (Fax：3186 2253 or email：kemoste@skhwc.org.hk)

Hong Kong Sheng Kung Hui Pilot Scheme on Multi-disciplinary
Outreaching Support Team for the Elderly (Kowloon East 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 ☑):
#Please circle the subordinate units
☐ Home Staff ☐ Resident ☐ Family Member of Resident
☐ 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 ☑)			
☐ A. Physiotherapy	**☐B. Occupational Therapy**	**☐ C. Speech Therapy**	**☐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：_____

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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 ☑)：

	☐ **Physiotherapy**	☐ **Occupational Therapy**	☐ **Speech Therapy**	☐ **Linkage Activity**
Service Content	☐ Pain management ☐ Balance training ☐ Mobility training ☐ Muscle strengthening ☐ Joint mobilization ☐ Aids prescription / consultation ☐ Others：_____	☐ Fine motor skill training ☐ Maintain/ enhance the upper limb function training ☐ Maintain/ enhance self-care ability ☐ Maintain/ enhance ADL function ☐ Maintain/ enhance cognitive function ☐ Carer training ☐ Sensory stimulation ☐ Suggest suitable aids ☐ Others：_____	☐ Speech training ☐ Language / communication training ☐ Swallowing training ☐ Oral-motor training ☐ Saliva / oral hygiene management ☐ Meal observation ☐ Carer feeding training/ consultation ☐ Diet modification ☐ Others：_____	☐ Various social activities ☐ Leisure activities ☐ Concern Visit ☐ 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)