

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

Referral Form 《for Self-financing and Contract 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 Speech Therapy Service(s) :
For example : Swallowing training, oral-motor training, diet modification, carer feeding training/consultation
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/ Family member's signature : _____
Date : _____ Home/ Institution Chop : _____

To: _____ (Home Name) 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) and follow up the referral case of _____ (Resident name).

2. After the assessment taken by Speech Therapist, the result of application is as follows (please):

2.1 Our team is unable to provide speech therapy service. Reasons: _____

2.2 Our team will provide speech therapy service, briefly summary is as follows:

2.2.1 General condition of the resident: _____

2.2.2 Follow-up plan as follows (please):

I) Service content: Speech training Language / communication training Swallowing training

Oral-motor training

Saliva/ Oral hygiene management

Meal observation

Carer feeding training/ consultation

Diet modification

Others: _____

II) Arrangement of service:

Provide weekly / monthly ____ sessions of speech services and reassess the service needs after ____ sessions.

2.2.3 Remarks: _____

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

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