**CENTRAL REFERRAL SYSTEM FOR REHABILITATION SERVICES**

**SUBSYSTEM FOR THE EX-MENTALLY ILL (CRSRehab-ExMI)**

**REGISTRATION FORM**

|  |  |
| --- | --- |
| Name of Applicant: |  |
|  | (This part should be completed for facsimile purpose) |

Instruction: Please use BLOCK LETTERS to fill the information or give a ‘√’ in the boxes, whichever is required.

**Part A**

1. **Source of Referral**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Case reference no. | | | |  | | | | | | |
| Name of referrer | | |  | | | | Signature | |  | |
| Office / Centre | |  | | | | |  | | |  |  |  | | --- | --- | --- | |  |  |  | | |
| Tel. no. |  | | | | Fax no. |  | | Date | |  |
|  | | | | | | | | | | |

1. **Personal Particulars**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| * + - 1. Name of applicant: | |  | | | | | | | | | | | | | | | | | ( | | |  | | | | | | | | | | ) |
| * + - 1. HKIC No.: |  | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | |
| * + - 1. Date of birth: |  | / | | |  | | | | / |  | | | | (DD/MM/YYYY) | | | | | | * + - 1. Sex: | | | |  | | | | | | | | |
| * + - 1. Residential district: | |  | | | | | | | | | | | |  | | | | | | | | | | |  |  | | --- | --- | |  |  | | | | | | | | | |
| * + - 1. Whether the client is living in institution or hospital?  No,  Yes | | | | | | | | | | | | | | | | | | Since (D/M/Y) | | | | | | |  | | | / |  | / |  | | |
| Name of institution or hospital: | | | | | | | | | | |  | | | | | | | | | | | | | | | | |  |  |  | | --- | --- | --- | |  |  |  | | | | | | |
| * + - 1. Medical History: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Psychiatric diagnosis: | | | |  | | | | | | | | | | | | | | | | | | | | | | |  |  | | --- | --- | |  |  | | | | | | | |
| Onset of mental illness in: | | | | | | |  | | | | | | | | | (YYYY) | | | | | | | | | | | | | | | | |
| Other illness, please specify: | | | | | | | |  | | | | | | | | | | | | | | | | | | |  |  | | --- | --- | |  |  | | | | | | | |
| A. Conditional discharge | | | | | | | | / | | | | | | | B. Unconditional discharge | | | | | | | | | | | | | | | | | |
| A. Intensive care case | | | | | | | | / | | | | | | | B. Non-intensive care case  B.1. Special care case  B.2. Conventional care case  C. Ex-intensive care case  A. Yes N. No | | | | | | | | | | | | | | | | | |
| Other medical history | | | A. Anti-social behavior | | | | | | | | | | | | | | B. Suicidal tendency | | | | | | | | | | | | | | | |
|  | | | C. Drug addiction | | | | | | | | | | | | | | D. Alcoholism | | | | | | | | | | | | | | | |
|  | | | E. Sexual deviation | | | | | | | | | | | | | | F. Others | | | | | |  | | | | | | | | | |
| * + - 1. Whether the case has been consulted with the case medical officer?  Yes or  No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| * + - 1. Other conditions | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Ex-offender | | | | | | N. No | | | | | | | A. Yes, with imprisonment | | | | | | | | B. Yes, without imprisonment | | | | | | | | | | | |
| Member of Triad Society | | | | | | N. No | | | | | | | A. Yes | | | | | | | | | | | | | | | | | | | |

1. **Particular of placement required**
   1. **Day Placement** *(please select by ticking one type of day placements only)*

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| *Code* | *Service Type* | | | *1st Location Preference* | | | | *2nd Location Preference* | | | | *3rd Location Preference* | | | |
| B | Sheltered Workshop | | |  | | | |  | | | |  | | | |
| For internal use only | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

* 1. **Residential Placement** *(please select by ticking one type of residential placements only)*

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| *Code* | *Service Type* | | | *1st Location Preference* | | | | *2nd Location Preference* | | | | *3rd Location Preference* | | | |
| C | Halfway house  [Subvented] | | |  | | | |  | | | |  | | | |
| L | Halfway house  [Subvented + Bought Place Scheme for Private Residential Care Homes for Persons with Disabilities] | | |
| E | Halfway house with special provision (previously known as Purpose-built Halfway House) | | |
| G | Long Stay Care Home [Subvented] | | |
| H | Long Stay Care Home [Subvented + Bought Place Scheme for Private Residential Care Homes for Persons with Disabilities] | | |
| I | Supported Hostel  [Subvented] | | |
| N | Supported Hostel  [Subvented + Bought Place Scheme for Private Residential Care Homes for Persons with Disabilities] | | |
| For internal use only | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

1. **Priority Placement**

Whether the client is in need of priority placement?  N. No  A. Yes (If yes, please give reason)

1. For referring units serving dischargees of correctional institutes, i.e. Siu Lam Psychiatric Centre and other prisons, please input the reasons for priority placement here.

2. For other referring units, please submit Form 1 together with Form 10 for the application in need of priority placement.

1. **Declaration**

Referrer has declared that there is no conflict of interest in handling this application. Referrer is not a family member or personal friend of the applicant and has no personal or social ties with the applicant.

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Endorsed by: | | | | | Prepared by: | | | | |
| Signature: | | |  | | Signature: | | |  | |
| Name: | |  | | | Name: | |  | | |
| Designation: | | | |  | Designation: | | | |  |
| Office: | |  | | | Office: | |  | | |
| Date: |  | | | | Date: |  | | | |

\*Please delete as appropriate

List of Location Preferences Codes

List of Residential District Codes

|  |
| --- |
| District |
| HC - Central & Western |
| HE - Eastern |
| HI - Islands |
| HS - Southern |
| HW - Wan Chai |
| EK - Kwun Tong |
| ES - Sai Kung |
| EO - Tseung Kwan O |
| EW - Wong Tai Sin |
| WK - Kowloon City |
| WM - Mongkok |
| WS - Shamshuipo |
| WY- Yau Ma Tei |
| NK - Kwai Tsing |
| NW - Tsuen Wan |
| NO - Ma On Shan |
| NN - North (Sheung Shui, Fanling) |
| NS - Shatin |
| NT - Tai Po |
| NU - Tin Shui Wai |
| NM - Tuen Mun |
| NY - Yuen Long |