**RESTRICTED**

**Reply to CRSRehab-ExMI on Selection for Placement**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| From: |  |  | To: | Central Referral System for Rehabilitation Services  Subsystem for the Ex-Mentally Ill  Social Welfare Department  Room 901, 9/F Wu Chung House  213 Queen's Road East, Wanchai, Hong Kong |
|  | *(Name of Referring Office)* |  |  |  |
|  |  |  |  |  |
|  | *(Name of Organisation)* |  |  |  |
| Ref: |  |  |  |  |
| Tel: |  |  |  |  |
| Fax: |  |  | Tel: | 2892 5136 |
| Date: |  |  | Fax: | 2893 6983 |
|  | | |  | |

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| --- | --- | --- | --- | --- | --- | --- |
| **Application for placement to:** | |  | | | | |
|  | | *(name of rehabilitation unit)* | | | | |
| Name of applicant: |  | | HKIC No.: |  | CRSRehab No.: | D |

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| (✓ in the appropriate box) | | |  | | | | |
|  | **Applicant accepts the offer.** | | (For priority placement, the applicant is confirmed to have urgent service need.) | | | | |
|  | The following documents have already been sent to the rehabilitation unit for further action on | | | | | | / / |
|  | Chest X-Ray Report (Remarks: | | |  | ) | CRSRehab-ExMI Form 2 | |
|  | Others: |  | | | | | |

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|  | **Applicant declines the offer.** | | (The application will be removed from the concerned Day placement/ Residential placement waitlisting, please refer to CRSRehab Manual of Procedures) |
|  | Unfavourable location | | |
|  | Ill health / unstable mental or emotional condition | | |
|  | Temporary leave of Hong Kong / emigration | | |
|  | Open / supported employment | | |
|  | Lost trace of client | | |
|  | No longer in need of placement upon case review | | |
|  | Ability improved, upward movement required | | |
|  | Ability deteriorated, downward movement required | | |
|  | Self-withdrawal/ unmotivated / unwillingness | | |
|  | Already receiving day programme in rehabilitation unit (please specify): | | |
|  | Name of unit: |  | |
|  | Admission date: |  | |
|  | Others, please specify: |  | |
|  |  |  | |
|  | **For case declining BPS offer, please tick below box if residential service is no longer required** | | |
|  | (Case will be removed from waiting list directly) | | |

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|  | **Applicant is temporarily hospitalized.** | (not applicable to the applicants who are admitted to psychiatric hospital or psychiatric ward of general hospital, please refer to CRSRehab Manual of Procedures) |
|  | Name of Hospital: |  |
|  | Admission date: |  |
|  | Diagnosis/Treatment required: |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | | Signature: | |  | |
|  | | Name: | |  | |
|  | | Post: | |  | |
|  |  | |  | |  |
|  |  | |  | |  |
| c.c. Rehabilitation Unit ( ) Fax: ( ) | | | | | |