SAHK Jockey Club New Page Inn (transitional care & support for tetraplegics) G/F, Heng Yat House, Heng On Estate, Ma On Shan, N.T. Tel: 2631-2170 Fax: 2631-4777	Name of Applicant : Sex / Age : Address : Tel : **or affix FULL gum label with applicant's contact details here**

REFERRAL FORM - AMBULATORY DAY TRAINING PROGRAMMES

Our Ref. No.: TCSC-_____ Case Coordinator：_____

Medical Diagnosis: _____

Please tick (if applicable)

❑ Traumatic/Non-traumatic* Spinal Cord Involved Injuries
Level(s) of Injury _____ ASIA impairment Scale (AIS): _____

❑ Traumatic/ Non-traumatic* Brain Injuries

(* delete as appropriate)

Present Conditions:

Past Medical History:

Medical Notes: (* delete as appropriate)

❑ Contracted with infectious disease, please specify _____
and has / has not* been cured

❑ Colonized with multi-drug resistant organisms, please specify _____
and has / has not* been cleared.

If "not" in either case, please indicate to what extent it is under control _____

_____

Medication:	**X-ray / Other Investigation Findings:**

Reasons for Referral:

Follow-up Tasks Needed (e.g., assistive device, mobility aid, home modification, counseling, etc)**:**

The applicant □agrees / □ disagrees to authorize SAHK to access his/her ePR for his/ her healthcare and other related purposes.

Referrer's Information:

Hospital / Special Clinics _____

Name:	Tel:	**(Official Chop)**
Post:	Fax:	
Signature:	Date:	