SAHK
Jockey Club New Page Inn
(for rehabilitation of tetraplegics)
Address: G/F., Heng Yat House, Heng On Estate, Ma On Shan, Shatin, N.T.
Tel.: 2631-2170 Fax: 2631-4777

REFERRAL FORM - TRANSITIONAL RESIDENTIAL SERVICE

Our Ref. No.: TCSC-__________ Case Co-ordinator：__________________

PART I (to be filled by Medical Social Worker)
Or affix FULL gum label with applicant's contact details here

1. Personal Particulars

Name of Applicant: ______________ (Chinese) ________________________ (English)

HKID Card No.: ________________ Date of Birth: ______________ (dd/mm/yy)

Sex / Age: ______________ Language/s used: _____________ Religion: __________________

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed

Address: (English) ____

____

(Chinese) ____

Housing status(Please tick if applicable):

☐ Public Housing ☐ Private Housing ☐ Home Ownership Schemes ☐ Compassionate Rehousing(CR): pending/ in progress
☐ Self-owned ☐ Rent

Telephone No: (Home) ____________________ (Mobile) ________________________

2. Family Composition

Name (Chinese & English)	Relationship	Sex/Age	Occupation	Contact number	Remarks: Illness /Disability / Others

3. History of present illness:

____

____

____

____

____

4. Psycho-social background

Family background (Matrimonial / Children/ Extended family member relationship) (if applicable):

____

____

____

____

Other significant support networks: ____

____

____

Special concern (mental health/ special behavior) (if applicable): ____________________

____

____

Motivation to resume community living: ❑ Highly motivated ❑ Moderately motivated

5. Assistance Received

Services	Name of Agency & Contact Person	Tel.
a. ____________	______________________________	__________
b. ____________	______________________________	__________
c. ____________	______________________________	__________
d. ____________	______________________________	__________

6. Rehabilitation Plan for the Applicant upon Discharge from Hospital

Long-term Accommodation arrangement: (if the applicant is waiting for Compassionate Rehousing, please provide details of the progress) ____

____

____

Caregiver/s arrangement: ____

____

____

Financial support and arrangement (if the applicant is waiting for compensation, please provide the details of relevant departments/organizations, the responsible worker and contact etc.):

____

____

____

Home Modification:

☐ not yet started ☐ in progress ☐ in progress and to be completed by the referrer

Responsible person: ______________________ Tel No.: ______________________

Progress details: ____

____

____

Placement details:

Length of Placement required: _______________ weeks/months (maximum stay is 12 months)

Does the applicant and/or the family members/caregiver understand and agree to leave the Centre upon the end of the contracted period? ❑ Yes ❑ No

eHealth:

Registration of eHealth: ❑ Yes, eHealth authorization code: _______________

❑ Not yet (please assist applicant to register)

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

Referrer's Information:

Name of Hospital / Special Clinics: ____

Address: ____

Case File No.: __________________ (if applicable for ongoing communication reference)

Name: ___________________ Tel. No.: _______________ Fax No.:________________

Signature: ________________________ Date: _________________

* Please enclosed all relevant documents and fax with this Referral Form to 2631-4777.

PART II (to be filled by Medical Officer, Nursing or Allied Health Professionals)

MEDICAL DIAGNOSIS

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)

MEDICAL NOTES

❑ 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: ______________________________

PAST MEDICAL HISTORY

Past Medical History:____

____

FOLLOW-UP CLINICS

Clinic	Details		
Clinic Type (circle one): SCI / Orthopedic / Medical / Urology / Other(specify): ______________________	Out-Patient No.:	Follow-up Frequency:	
	Hospital/Clinic Name:		Phone:
Clinic Type (circle one): SCI / Orthopedic / Medical / Urology / Other(specify): ______________________	Out-Patient No.:	Follow-up Frequency:	
	Hospital/Clinic Name:		Phone:
Clinic Type (circle one): SCI / Orthopedic / Medical / Urology / Other(specify): ______________________	Out-Patient No.:	Follow-up Frequency:	
	Hospital/Clinic Name:		Phone:

MEDICATION INFORMATION

Medication:	Dosage:	Frequency:	Remarks:

PATIENT / CAREGIVER INSTRUCTIONS

Nutrition: ○ No restrictions ○ Instructions given	❑ Special diet	❑ PEG ❑ NG tube
	❑ Supplements/other	
Daily Activities: ○ No restrictions ○ Instructions given	❑ Transfer	Aid:
	❑ Mobility	Aid:
	❑ Dressing/Undressing	Aid:
	❑ Eating/Drinking	Aid:
	❑ Bathing	Aid:
	❑ Toileting	Aid:
	❑ Other	

<table>
<tr><td rowspan="5">Special Care:
○ No restrictions
○ Instructions given</td><td>❑ Bladder</td><td>❑IMC ❑Foley</td></tr>
<tr><td>❑ Bowel</td><td></td></tr>
<tr><td>❑ Skin</td><td>❑Wound ❑Rash
Location:______________________________</td></tr>
<tr><td>❑ Ulcer/Sore</td><td>Location:
Solution:
Duration:</td></tr>
<tr><td>❑ Other</td><td></td></tr>
<tr><td rowspan="4">Precaution:
○ No restrictions
○ Instructions given</td><td>❑ Thermoregulation</td><td></td></tr>
<tr><td>❑ Autonomic Dysreflexia</td><td></td></tr>
<tr><td>❑ Chest</td><td></td></tr>
<tr><td>❑ Other</td><td></td></tr>
</table>

FOLLOW-UP TASKS

Assistive Device / Mobility Aid:	Supplier:	Contact Person (Phone no.):	Remarks:

SPECIAL REMARKS AND PRECAUTIONS

Name of Referrer (Post)	*Referrer signature*	*Date*