



Care4ALL Programme

(Organised by the Hong Kong College of Psychiatrists)



REFERRAL FORM A (Non- Government Organizations / Social Workers / Clinical Psychologists / School or Educational Institutes Personnel / HKCPsych Secretariat)

A. Participant Information*			
Surname (English)		Surname (Chinese)	
Gender (F/M)		AGE	
HKID (First 4 digits)		Contact Number	
Occupation		Email Address	
Residential Area (District)	<input type="checkbox"/> Central & Western <input type="checkbox"/> Eastern <input type="checkbox"/> Southern <input type="checkbox"/> Wanchai <input type="checkbox"/> Kowloon City <input type="checkbox"/> Kwun Tong	<input type="checkbox"/> Sham Shui Po <input type="checkbox"/> Wong Tai Sin <input type="checkbox"/> Yau Tsim Mong <input type="checkbox"/> Islands <input type="checkbox"/> Kwai Tsing <input type="checkbox"/> Northern	<input type="checkbox"/> Sai Kung <input type="checkbox"/> Sha Tin <input type="checkbox"/> Tai Po <input type="checkbox"/> Tsuen Wan <input type="checkbox"/> Tuen Mun <input type="checkbox"/> Yuen Long
B. Eligibility Screening Criteria*			
i. Suspected mental health problems are directly related to the recent social unrest, and he/she is in need of psychiatric assessment and care <input type="checkbox"/> Yes <input type="checkbox"/> No (Not eligible)			
ii. Has been seen by a psychiatrist (private/public) in the past 2 years <input type="checkbox"/> Yes (Not eligible) <input type="checkbox"/> No			
iii. Currently under legal investigations / proceedings with offences <input type="checkbox"/> Yes (Not eligible) <input type="checkbox"/> No			
iv. The participant understands that he/she will receive 8 free psychiatric consultation sessions and a maximum medication subsidy of HKD\$6,000. The participant agrees to be responsible for his/own medication fee if it exceeds HKD\$6,000. <input type="checkbox"/> Yes <input type="checkbox"/> No (Not eligible) <i>(If yes, please remind participants he/she has the right to obtain prescriptions of medication from community dispensaries.)</i>			
C. Family Information (Optional)			
Household members	<input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Siblings <input type="checkbox"/> Others		
Number of Siblings		Sibling Ranking	
Family History of Mental Illness	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please state:		



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D. Background Information*

i. Is the participant currently undergoing / on waiting list of public outpatient clinic?

Yes

a) Registration Date:

b) Appointment Date:

c) HA Clinic:

No Does the participant agree to be waitlisted on the public outpatient clinic?

Yes – Inform participant to make request to the volunteering psychiatrist to write referral letter for outpatient clinic of the Hospital Authority if judged to be clinically appropriate at the first appointment

No – Remind participant that the current programme only provides 8 consultation sessions excluding other services. The participant would need to pay the regular consultation fees for sessions thereafter

ii. Suspected Issues:

Depression Anxiety PTSD Others:

iii. Physical Health Concerns:

Yes No

If yes, please state:

E. Referrer's Information (if applicable)

Organization		Service Unit	
Referrer's Name		Position	
Email		Contact Number	
Service Unit Address			
Participant's Financial Status	<input type="checkbox"/> CSSA <input type="checkbox"/> Others:		
Preferred attributes of Psychiatrists (e.g.: Gender , Language)			

F. Volunteer Psychiatrist Consultation Arrangement (To be completed by HKCPsych Secretariat)

Case Number			
Name of Psychiatrist		Contact Number	
Venue for Consultation			