Care4ALL Programme

(Organised by the Hong Kong College of Psychiatrists)

REFFERAL 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)	☐ Central & Western ☐ Eastern ☐ Southern ☐ Wanchai ☐ Kowloon City ☐ Kwun Tong	☐ Sham Shui Po ☐ Wong Tai Sin ☐ Yau Tsim Mong ☐ Islands ☐ Kwai Tsing ☐ Northern	☐ Sai Kung ☐ Sha Tin ☐ Tai Po ☐ Tsuen Wan ☐ Tuen Mun ☐ Yuen Long

B. Eligibility Screening Criteria*

i. Suspected mental health problems are directly related to recent social events (including social unrest and COVID-19), and he/she is in need of psychiatric assessment and care

☐ Yes ☐ No (Not eligible)

ii. Has been seen by a psychiatrist (private/public) in the past 2 years

☐ Yes (Not eligible) ☐ No

iii. Currently under legal investigations / proceedings with offences

☐ Yes (Not eligible) ☐ 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.

☐ Yes ☐ No (Not eligible)

(If yes, please remind participants he/she has the right to obtain prescriptions of medication from community dispensaries.)

C. Family Information (Optional)			
Household members	☐Father ☐Mother ☐Siblings ☐Others		
Number of Siblings		Sibling Ranking	
Family History of Mental Illness	☐ Yes ☐ No If yes, please state:		

The information provided is for service matching and overall analysis by the Secretariat of the Hong Kong College of Psychiatrists. It will be destroyed within one year after completion of the project. If you have any questions, please contact the Programme Secretariat | Tel 6020 2493 | Fax 2870 1391 | Email care4all@hkcpsych.org.hk

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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	☐ CSSA ☐ 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			