

For official use only
 Referral code: _____
 Acknowledgement date: _____

Heep Hong Society Hoi Fu Parents Resource Centre
Project EMbrace

Child Assessment Referral Form

From: _____ _____ Name of Referrer: _____ Telephone no.: _____ Fax no.: _____ Date: _____	To: Heep Hong Society Hoi Fu Parents Resource Centre Attn: Miss Cheong Yi Ling, Elaine Telephone no.: 2777 5588 Fax no.: 2784 1194 Total no. of pages: _____
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Client details	
Name of the child:	_____
Age of the child:	____year ____month
Gender of the child:	Male/ Female
Name of the parent:	_____
Age of the parent:	_____
Relationship with the child:	_____
Gender of the parent:	Male/ Female
Telephone no.:	_____
Preferred contact time:	<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening
Address:	_____ _____ <i>(Address proof is needed for non-school social worker referral)</i>
Client's informed consent to referral:	<input type="checkbox"/> Verbal consent <input type="checkbox"/> Written consent
Cultural profile	
Ethnicity:	<input type="checkbox"/> Nepalese <input type="checkbox"/> Indian <input type="checkbox"/> Pakistani <input type="checkbox"/> Thai <input type="checkbox"/> Filipino <input type="checkbox"/> Others: _____
Religion:	<input type="checkbox"/> Muslim <input type="checkbox"/> Buddhism <input type="checkbox"/> Hinduism <input type="checkbox"/> Sikhism <input type="checkbox"/> Others: _____
Language competence: Spoken:	<input type="checkbox"/> English <input type="checkbox"/> Nepali <input type="checkbox"/> Urdu <input type="checkbox"/> Hindi <input type="checkbox"/> Others: _____
Written:	<input type="checkbox"/> English <input type="checkbox"/> Nepali <input type="checkbox"/> Urdu <input type="checkbox"/> Hindi <input type="checkbox"/> Others: _____
Interpretation needs:	<input type="checkbox"/> No requirement <input type="checkbox"/> Prefer Nepali/ Urdu/ Hindi/ Others: _____
Any preference for gender and ethnicity of the worker?	
<input type="checkbox"/> No <input type="checkbox"/> Yes, prefer _____	

Family background			
Family members	Age	Relationship with the child	Occupation/Education level

Financial situation
<input type="checkbox"/> Comprehensive Social Security Assistance (Please provide document proof of CSSA) <input type="checkbox"/> Low-income family (Please provide income proof of latest 3 months)
Client's presenting problem (e.g. suspected type of SEN)
Reasons for referral

Signature of referrer: _____

Date: _____

Signature of parent: _____

Date: _____

Submission method:

Please submit the completed referral form with the copy of supporting documents* to the project social worker Miss Elaine by email (elainecheong@heephong.org) or fax (2784 1194).

*Supporting documents include the income proof of latest 3 months, document proof of CSSA and address proof (only for non-school social worker referral)

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Referral code: _____
Acknowledgement date: _____
Responsible staff: Miss Cheong Yi Ling, Elaine
Is the referral request accepted? <input type="checkbox"/> Yes <input type="checkbox"/> No, Reasons: _____
Responsible psychiatrist/ psychologist: _____
Date of assessment: _____