

Community Rehabilitation Project Referral Form

Data of Application: _____ Our Reference no.: C R P

Client's Personal Particulars

Name: _____(Chinese) _____(English)

Age: _____ Sex: _____ HKID no.: _____ () Tel no.: _____

Home Address: _____

C.S.S.A. no.: _____ Occupation: _____

Disabilities: _____

Reason of Referral: _____

Category (can choose more than one): ☐ Emergency ☐ Non-emergency

☐ Without receiving any subvented or private allied health service

☐ Without making multi-referral ☐ Cannot provide community OT service

Details of Referrer/Contact Person

(Referral should be made by registered medical officer, allied health professionals or social worker)

Name: (Mr./Ms.) _____ Position: _____

Organization: _____

Address: _____

Tel no.: _____ Fax no.: _____ E-mail: _____

Remarks: _____

(Note: Provided by client's personal particulars will be regarded as accurate and complete, and all information will be provided to the voluntary nature of such information that will be used only for the service-related matters, the client for a personal inspection and the right to information.)

Renewal Date: 1.6.2021