

醫院管理局  
復康專科及資源中心與扶輪兒童復康專科及資源中心  
轉介申請表  
(適用於接受社區服務人士)

HOSPITAL AUTHORITY  
REHABAIID & ROTARY REHABAIID CENTRES  
CLIENT REFERRAL FORM  
(Applicable to Clients Receiving Community Service)

轉介機構資料 REFERRING AGENT INFORMATION

醫院管理局屬下機構

Hospital Authority Institution

是 YES  否 NO

轉介人姓名

Name of Referer: \_\_\_\_\_

電話號碼

Telephone number: \_\_\_\_\_

職位/部門

Post/Department: \_\_\_\_\_

圖文傳真

Facsimile number: \_\_\_\_\_

轉介機構

Referral Agency: \_\_\_\_\_

地址

Address: \_\_\_\_\_

轉介人簽署

Signature of Referer: \_\_\_\_\_

轉介日期

Date: \_\_\_\_\_

申請人資料 CLIENT INFORMATION

申請人中文姓名

Name of client (Chinese): \_\_\_\_\_

英文

(English) \_\_\_\_\_

性別

Sex/Age: \_\_\_\_\_

出生日期

Birth Date: \_\_\_\_\_

身份証號碼

H.K.I.D. No.: \_\_\_\_\_

地址

Address: \_\_\_\_\_

電話號碼

Tel. No.: \_\_\_\_\_

聯絡人姓名 (如適用者)

Contact Person (if applicable): \_\_\_\_\_

專科醫療類別 Specialty of Medical Service: \_\_\_\_\_

症狀及個案撮要 Diagnosis & Case Summary:

所需專科服務

Specialty Service Required:

- |  |  |  |   |   |
|--|--|--|---|---|
| <input type="checkbox"/> 輪椅選用及訓練<br>Wheelchair Assessment & Training | <input type="checkbox"/> 電腦應用<br>Computer Access | <input type="checkbox"/> 傷殘人士駕駛<br>復康<br>Driver Rehabilitation                             | <input type="checkbox"/> 思維訓練<br>Cognitive Rehabilitation   | <input type="checkbox"/> 生活環境輔導<br>Environmental Advisory Service<br>(Architectural Consultation) |
| <input type="checkbox"/> 壓瘡預防及處理<br>Pressure Care                    | <input type="checkbox"/> 背部護理<br>Back Care       | <input type="checkbox"/> 性復康<br>Sexual Rehabilitation                                      | <input type="checkbox"/> 學習及動作協調<br>障礙服務<br>Service for Children with Developmental Coordination Disorder | <input type="checkbox"/> 全人健康<br>Wellness Enhancement   |
| <input type="checkbox"/> 腦震盪後症候群<br>Post-Concussion Syndrome         |  | <input type="checkbox"/> Fall Prevention and Bone Mineral Density Enhancement<br>防跌及骨質密度治療 |   | <input type="checkbox"/> Community-Based Chronic Pain Management<br>長期痛症社區復康                      |
| <input type="checkbox"/> 殘疾人士輔導服務<br>Disability Coping Counselling   |  |  |   |   |

其他服務需要 Other Service Required:

轉介目的 Referral Objective:

\*如有需要, 請另加附頁。

Please attach a supplementary sheet if the space provided is insufficient.

Please fax this form to: Rehabaid Centre: 2764 5038 for adult clients, Rotary Rehabaid Centre: 2819 8041 for children clients

For enquiry, please phone: 2364 2345 (Rehabaid Centre) or 2817 5196 (Rotary Rehabaid Centre)

Form revised on August 10, 2010