To: Responsible Staff **(By Fax: 3186 2253 or Email: kemsote@skhwc.org.hk** / Tel. no.: **3598 9120)**

Hong Kong Sheng Kung Hui Multi-disciplinary
Outreaching Support Team for the Elderly(Kowloon East Cluster) ("MOSTE")
Application/ Referral Form (for Private Residential Care Homes for the Elderly)

Particulars of Service User: (**Please delete as appropriate, and tick ☑ as appropriate)*

1. Name of Residential Care Home: _____ ("RCHE")
2. Name of Applicant / Resident: _____ 3. HKID No.: _____ ( )
4. Gender*: Male / Female 5. Date of birth: _____ 6. Bed No.: _____
7. Mobile Phone No. of Applicant/ Resident: _____
8. Mobile No. of Family Member: _____ 9. Relationship: _____
10. RCHE Contact Person: _____ 11. Telephone No.: _____ 12. Fax: _____
13. Name of Referrer: _____ 14. Telephone No.: _____ 15. Fax: _____
16. Background of Applicant/ Referrer: ☐ Applicant ☐ RCHE Staff ☐ Applicant/ Family Member of Resident
    ☐ Multi-disciplinary Outreaching Support Team for the Elderly (MOSTE)
    ☐ Hospital Authority (HA) *: (CGAT / PGT / CNS / PT / OT/ ST / MSW / Other:_____)
    ☐ Visiting Health Team/Elderly Health Service (DH)
    ☐ Visiting Medical Practitioner Service for Residential Care Homes (VMPS)
    ☐ Visiting Medical Officer (VMO) ☐ Other (please specify):_____
17. Services Receiving: ☐ CGAT's treatment or rehabilitation equipment purchasing services
    ☐ Geriatric Day Hospital (GDH) ☐ Palliative Care
18. Current Condition of Applicant/ Resident *(according to observations within the past 30 days; multiple options are allowed):*

Self-care skills:

☐ Walk independently ☐ Walking with assistance ☐ Wheelchair required (☐ Indoor/☐ Outdoor)
☐ Transfer from bed to chair with assistance (☐ Low/☐ Medium/☐ High)
☐ Walking aid (☐ Indoor/☐ Outdoor) / (☐ Crutches /☐ Quadripod /☐ Walking frame /☐ Others:_____) ☐ Bed bound
☐ Musculoskeletal pain (area:_____) ☐ Recent falls____times in____days
☐ Muscle weakness/ decreased range of motion (area:_____) ☐ Dressing assistance (☐ Mild/☐ Moderate/☐ Maximum)
☐ Toileting assistance (☐ Mild/☐ Moderate/☐ Maximum) ☐ Feeding assistance (☐ Mild/☐ Moderate/☐ Maximum)
☐ Other:_____

Cognitive functioning:

☐ Normal ☐ Mild Impairment ☐ Moderate Impairment ☐ Severe Impairment
☐ Acute deterioration in cognitive functioning, judgment and memory
☐ Behavioral problems, (e.g.:_____)

Speech and Swallowing functions:

☐ Express fluently / ☐ Simple expression only / ☐ Non-communicable
☐ Normal comprehension / ☐ Difficulty in understanding daily commands
☐ Regular diet / ☐ Minced diet / ☐ Pureed diet / ☐ NG tube-feeding /☐ Gastrostomy-feeding
☐ No thickener required / ☐ Require thickener ☐ Cough or pant during mealtime ☐ Reluctant to eat/ ☐ Difficulty in feeding

Chronic Illness:

☐ None ☐ High/ Low Blood Pressure ☐ Cardiac illness ☐ Diabetes Mellitus ☐ Parkinson's Disease ☐ Dementia
☐ Stroke ☐ Amblyopia/ Blind ☐ Amblyacousia/ Deaf ☐ Pressure Ulcer ☐ Others (please specify:_____)

Psychiatric Illness:

☐ None ☐ Depression ☐ Anxiety Disorder ☐ Manic-Depression ☐ Schizophrenia ☐ Other, (please specify:_____)

Physical Disabilities:

☐ None ☐ Quadriplegic ☐ Lower limbs paralysis ☐ Left/Right hemi-paralysis
☐ Deficiency of upper/ lower limb(s) ☐ Deficiency of palm/ sole or finger/ toe

Social Aspect:

☐ Normal ☐ Passive ☐ Withdrawn ☐ Reluctant to participate

Adjustment to residential setting:

☐ Satisfactory ☐ Acceptable ☐ Poor adjustment

Suffering from infectious disease upon the referral:

☐ Yes (please specify:_____) ☐ None

19. Expected Service(s)**:**

Service Type			
☐ **A. Physiotherapy**	☐ **B. Occupational Therapy**	☐ **C. Speech Therapy**	☐ **D. Social Work Services**

20. Special needs or areas of the Applicant/Resident that require special attention of MOSTE (if any):_____

_____

_____

21. Remarks:_____

Notes for Application/ Referral:

- MOSTE provides physiotherapy, occupational therapy, speech therapy and social work linking programs. Services to be provided will be based on assessment result of MOSTE.
- If the Applicant/ Resident is suspected of suffering from infectious disease(s), the Applicant('s)/ Resident's family member and/ or RCHE understand(s) and agree(s) that MOSTE may suspend services for that Applicant/ Resident until (s)he is fully recovered from the infectious disease(s) for the protection of other service users and service providers.
- The outreach service provided by MOSTE is free of charge. However, any personal items to be purchased by the Resident shall be paid by the Applicant/ Resident her/himself.

Authorization and Declaration: (Please delete as appropriate, and tick ☑ as appropriate)***

Remarks : 1. For mentally incapacitate Applicant/ Resident, his/her family member or guardian may sign on his/ her* behalf and fill in the "relationship" column, for example, husband/ wife/ mother/ father/ brother/ sister/ sister/ guardian.

2. RCHE can sign on behalf of the Applicant/ Resident, family member and/ or guardian upon obtaining his/ her/ their consent and authorization.

- ☐ We have obtained the consent and authorization from the Applicant/ Resident, his/ her* family member and/or guardian for signing the following declaration:
- ***I/ Resident* agreed*** to receive services from MOSTE of Sheng Kung Hui Welfare Council (the "Welfare Council"), agreed to accept and comply with the following service terms.
- ***I/ Resident**** ☐***agreed/*** ☐***disagreed*** that the photos/recordings/videos taken by MOSTE be used for professional training, event introduction, publicity, promotion, academic study, report and other related purposes by the Welfare Council and related bodies.
- ***I/ Resident* agreed and authorized*** the Welfare Council to transfer and disclose my/ the Resident's personal data, including but not limited to name, phone number, medical history and medication record, to the following parties on a need-to-know basis: 1) staff of relevant departments and units of the Welfare Council; 2) insurance companies, doctors and/ or other service providers appointed by the Welfare Council; 3) other medical staff involved in the caring of the Resident (including but not limited to doctors of Hospital Authority and Visiting Medical Practitioner Service for Residential Care Homes (VMPS)); and 4) government departments or organisations with authorization or statutory power to obtain such information.
- The personal data provided by ***me/ Resident**** to the Welfare Council is on a voluntary basis, and understand that shall ensure the accuracy of all the data supplied. In case there is any changes of the data, ***I/ Resident**** shall notify the Welfare Council as soon as possible. ***I/ Resident**** shall be responsible for any service delay, injuries or death caused by any inaccurate data provided.
- Except the circumstances specified under the Personal Data (Privacy) Ordinance, ***I/ Resident**** have the right to apply for access to and/or correction of ***my/Resident's**** own personal data held by the Welfare Council. Application form and handling fee are required for any request for "access to personal data" or "a photocopy of personal data". For enquires or application, please contact the person in charge of MOSTE (Email:_____ / Tel. no.: _____).

Name of Applicant/ Resident: _____

Name of Applicant/ Family member/ Guardian/ RCHE representative*: _____ Signature: _____

Home/ Institution Chop: _____ Date: _____