Tung Wah Group of Hospitals
Alcohol Abuse Prevention and Treatment Service

Case Referral Form

Tel：2884 9876 Fax：2884 3262

Confidential

(I) Referring Agency

Name of Agency / Hospital / Clinic：_____

Name of Referrer：_____ Tel：_____ Fax：_____

(II) Case Background

1. Name: _____(English)_____(Chinese)
2. Sex: _____ Date of Birth(Age) : _____(Month/Year) (___)
3. ID No: _____XXX (X)
4. Tel. No. : _____(Mobile)_____(Home)
5. Address: _____
6. Occupation/Educational level: _____
7. Drinking History (age onset, consumption pattern, etc.):

8. Previous intervention received:

9. Reason(s) of referral / Service need:

10. Remarks (e.g. mental state, violent behaviour):

Signature of Referrer：_____
( )

Date：_____

Application in the absence of **client's written consent** will NOT be accepted, thank you.