Jockey Club CADENZA Hub
賽馬會流金匯

Appendix 1.4.2

Service Application Form

Service Applying: ☐Day care ☐Hub's bus ☐Case management

Frequency per week: ______(time)/every __________)
Pick up and alighting point: __________________________

A. Personal Particulars of Service User

Name: ______________________ (Chinese) ______________________________ (English) Sex: _____

Date of Birth: _______________ (dd/mm/yy) Age: ______ HKID No.: ______________________

Province: ___________ Dialect: ___________ Occupation before Retirement: ____________________

Address: ____ Tel: __________________

Marital Status: ☐Single ☐Married ☐Divorced/Separated ☐Widowed No. of Children: __________

Education Level: ☐Illiterate ☐No schooling but literate ☐Primary ☐Secondary ☐Tertiary or above

Living Condition: ☐Live alone ☐With *spouse/domestic helper ☐With family
No. of co-living members: _____person(s)

Economic Condition: ☐Support by family ☐Savings/Pension ☐Government subsidy ☐Others: _______

Religion: ☐Nil ☐Christianity/Catholic ☐Taoism ☐Buddhism ☐Worship to ancestors ☐Others: ____

***please delete as appropriate**

I. Health Conditions

1. Diagnosis: ☐Dementia (*Alzheimer's disease/vascular disease/others: _______________________)
Year of Diagnosis: __________ Doctor/Location: _______________________________

☐Hypertension ☐Diabetes ☐Heart Disease ☐Cancer ☐Stroke ☐Arthritis

☐Lung disease ☐Cataract ☐Kidney disease ☐Epilepsy ☐Parkinson's disease

☐Mental illness ☐Others: ____

2. Medical Follow Up Arrangement:

Hospital/Clinic	Specialty	Next Follow Up Date	Remarks

3. Current medication: ____________ (no. of type)

4. Admission to hospital in the past 6 months: ☐No ☐Yes (please specify: __________________)

5. Fall in the past 6 months: ☐No ☐Yes (please specify: ____________________________)

6. Surgery done: ☐No ☐Yes (please specify:____)

7. Contagious disease: ☐No ☐Yes (please specify: ________________________________)

8. Skin condition: ☐Normal ☐Dry ☐Itchy ☐Abrasion ☐Swelling or red

9. Swallowing: ☐Normal ☐Occasional choking ☐Have attended speech therapist before

☐Use of thickener for drinks

10. Allergy to food/drug/others: ☐No ☐Yes (please specify: _____________________________)

11. Diet: ☐Ordinary ☐Minced meal ☐Low salt ☐Diabetic ☐Others (please specify: ______)

12. Denture: ☐No ☐Yes

13. Smoking: ☐Never ☐Yes ☐Quitted for ________year(s)

14. Alcohol drinking: ☐Never ☐Yes ☐Quitted for ________year(s)

II. Cognitive Capacity

Item	No problem	Some problems	Severe problem	Remarks
1. Memory	☐	☐	☐	______
2. Tell own name	☐	☐	☐	______
3. Know the route to home	☐	☐	☐	______
4. Articulate clearly	☐	☐	☐	______
5. Understand verbal instruction	☐	☐	☐	

III. Expression and Communication

Item	Normal	Impaired	Aid needed	Remarks
1. Visual	☐	☐	☐	______
2. Hearing	☐	☐	☐	______
3. Speaking	☐	☐ (please specify:)		

IV. Social Capacity

1. Social interaction	☐Cooperative	☐Resistant	☐Indifferent
2. Initiative	☐Independent	☐Need reminding	☐Total dependence
3. Mood	☐Appropriate	☐Depressed	☐*Hyper/Angry
4. Behaviour	☐Normal	☐Passive	☐*Hyper-active/Prone to violence

V. Self Care Capacity

Item	Self Help	One Assistant Required	Severe Problem/ Two Assistants Required	Remarks
1. Overall self care capacity	☐	☐	☐	Care by domestic helper: *Yes/No
2. Eating	☐	☐	☐	
3. Toileting	☐	☐	☐	Diaper use: *Yes/No
4. Bathing	☐	☐	☐	
5. Walking/Transfer	☐	☐	☐	Walking aid use, please specify:

VI. Mental State: ☐Normal ☐Confused ☐Delusion ☐Hallucination – auditory

☐Hallucination – visual ☐Others: ____

VII. Sleeping: ☐Normal ☐Insomnia ☐Normal with sleeping pills ☐Inverted night and day☐Unstable

VIII. Community Service Receiving:

☐No ☐Yes, please specify: ____

IX. Others:

Favourite food: ☐No ☐Yes (please specify: ________________________________)

Favourite activities/matters: ☐No ☐Yes (please specify: ________________________________)

*Hateful/Sorrowful matters: ☐No ☐Yes (please specify: ________________________________)

***Please delete as appropriate**

B. Personal Particulars of Applicant/Carer

Name:______________________________ Sex: ____________ Relationship: ___________________

Address: ____

Day Contact No.: ____________________________ Mobile No.: ______________________________

Current Occupational Status: ☐Part time ☐Full time ☐Retired ☐Housewife

Reason of application/Expectation: ____

Where did you know about the service?

- ☐ Public hospital doctor, please specify name: ____
- ☐ Private doctor, please specify name: ____
- ☐ Hospital, please specify hospital name and department: _________________________________
- ☐ Social service organization/professional, please specify: _______________________________
- ☐ Relative/Friend, please specify: ____
- ☐ Others, please specify: ________________________________

Name of major carer (if different from applicant): ________________ Relationship: ______________

Carer's stress level (1 mark as very low, 10 marks as very high): ________

Signature of Applicant: __________________

Date: __________________________________

*** Please send the completed application form with the medical assessment (to be completed by doctor) or medical referral to CADENZA Hub by fax on 3763-1100 or by mail to Wings A and B, Shin Lun House, Fu Shin Estate, Tai Po.**

Enquiry: 3763-1000

Remarks: The data provided in this form will be used for processing of service and statistical purposes only. Under the provisions of Personal Data (Privacy) Ordinance, you have rights to request access to and to make correction of the personal data in the form.

Medical Assessment

(To be completed by Doctor)

Name: Date:

Sex/Age:

HKID:

All Diagnoses (Including state of dementia):

History of Present Illness/Past Medical History:

Swallowing Problems: N Y

Tendency to fall: N Y

Allergies: N Y ______________________

Special Diet: N Y ______________________

Contagious Disease N Y______________________

Current Medication:

Investigations done:

Recommendations:

____

(Name of Doctor)

Contact tel no. ____________________