St James’ Settlement

Circle of Love Specialised Co-parenting Support Centre

Service Referral Form (Non-NGOs)

Please contact our intake worker at 3921 3909 before making referral. Please send the filled form to Room 5B, 5/F, Car Park, Tin Heng Estate, Tin Shui Wai, N.T. or fax to

3104 3699 (Attn: Centre-in-charge)

**Referrer’s Information**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(English) \_\_\_\_\_\_\_\_\_\_\_ (Chinese, if any)

Organization: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Position: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tel: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Consent(s) given by client (please tick as appropriate)

Residing parent 🗆 Yes 🗆 No

Non residing parent 🗆 Yes 🗆 No

**Client’s Information**

Residing Parent (RP)

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(English) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Chinese, if any)

Gender: male / female \_\_\_\_\_\_\_ \_\_\_\_Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tel: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Non-Residing Parent (NRP)

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(English) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Chinese, if any)

Gender: male / female \_\_\_\_\_\_\_\_ \_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tel: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Child(ren)

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Name  | Relationship with \* Son/ Daughter & Close/fair/detached) | Sex | Age DOB | Education/ Occupation  | Living with  | Remarks:Disability, SEN, Domestic violence … |
| Child | Father  | Mother  |  |  |  | Father | Mother  | Others  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |

**Service requested**

|  |  |  |  |
| --- | --- | --- | --- |
|  | Services | Child(ren) is required to serve in SCSC / age / gender) | Remarks |
| 🗆 | Supervised Contact  |  |  |
| 🗆 | Supervised Exchange |  |
| 🗆 | Parental Coordination  |  |
| 🗆 | Co-parenting Counselling |  |  |
| 🗆 | Co-parenting Workshop |  |  |
| 🗆 | Enquiry on SCSC service  |  |  |

Reason of Referral:

Signature of Referrer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_