



地址 : 香港九龍漆咸道南 9 號均輝大廈 6 樓
Address: 6/F., Hecny Tower, 9 Chatham Road South, Tsim Sha Tsui, Kowloon
電話 / Tel: 6014-0440
網址 / Website: www.hkamt.org 電郵 / Email: info@hkamt.org

RESTRICTED

MUSIC THERAPY SERVICE REFERRAL FORM

Part A : Assessment (to be completed by referrer)

Name of Client/ Sex/ D.O.B./ B.C. No./ Case Reference No.

Address/ Telephone

Date of Assessment/ Age at Assessment

1. Medical

Diagnosis: _____

2. Medication/ Special Precautions: _____

3. Physical

Findings: _____

4. Vision: _____

5. Hearing: _____

6. Motor
Function:

Lyer Sitter Walks with aid Walks well

Manages stairs: With adult's help Without adult's help

7. Intellectual Development: Age appropriate Suspected mild grade mental retardation
 Mild grade mental retardation Moderate to severe grade mental retardation
 Functional age level: _____

8. Speech and Language Development: Speech and language development appropriate for mental age
 Speech & language delay discrepant with intellectual development
 Other speech & language disorders, please specify:

9. Behavior: Unremarkable Attention problem with / without over activity
 Autism Psychomotor
 Psychotic features Others:

10. Self Care Skills:
 Feeding: Fed by adult Finger feeding
 Feeds self with spoon or chopsticks
 Toileting: Wets/ Soils Indicates needs Trained

11. Treatment & Training Completed/Receiving:

	<u>Centre / Clinic</u>	<u>Period (from _____ to _____)</u>
A. Music Therapy	_____	_____
B. Occupational Therapy	_____	_____
C. Physiotherapy	_____	_____
D. Speech Therapy	_____	_____



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- E. Auditory Training _____
- F. Training for Autistic Children _____
- G. Psychiatric Treatment _____
- G. Medical Treatment _____
- H. Training in Centres (e.g. EETC, SCCC, IP, DAC, etc.) _____

12. Others: _____

Part B: Social Background (to be completed by referrer)

1. Family Composition :

Name	Relationship	Sex/Age	Education Level	Occupation	Working Hours	Income/ School Fee

(please indicate the day time caregiver with '')*

2. Type of accommodation: _____ Rent/Mortgage: _____

3. Availability of escort to centre: _____



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4. Family interaction:

5. Other Services Rendered to Child & Family:

	<u>Ref. No. (if any)</u>	<u>Name of Office</u>
Disability Allowance	_____	_____
Comprehensive Social Security Assistance	_____	_____
Family Services	_____	_____
Others (Please specify)	_____	_____

6. Monthly family (for those aged below 18) or personal (for those aged 18 or above) income:

7. Supplementary Comments:

8. Particulars of referrer:

Name of Referrer: _____ Telephone no.: _____

Name of Referring Office: _____ Fax no.: _____

Address of Referring Office: _____

_____ File ref. in Referring Office: _____

Signature of Referrer: _____

Post / Rank: _____

Date: _____



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音樂治療報名表

Music Therapy Application

密件
CONFIDENTIAL

檔案編號 / File No. : _____
日期 / Date : _____
姓名 / Name : _____
年歲 / Age : _____
出生日期 / Birthday : _____
家長 / Parent : _____
聯絡電話 / Contact Number : _____
電郵 / Email : _____
住址 / Home Address : _____

轉介原因 / Referral Reason(s): _____

治療師填寫部分 / Therapist's Assessment :

C: _____

A: _____

M: _____

E: _____

S: _____

Other Observation: _____

Prescription : 30 minutes / 45 minutes / 1 hour session

Date of Termination : _____