

**Referral Form for  
KID First Specialised Co-parenting Support Centre Services  
(\*HK/KE Cluster)**

Referring Agency / Service Unit : \_\_\_\_\_

Reference Number : \_\_\_\_\_

Tel No./Fax No. : \_\_\_\_\_

**1. Particulars of Father and Mother**

	Father	Mother
	Put a 「✓」 in <input type="checkbox"/> for the principal client of referrer (if applicable)	
Name (Chinese) (English)	<input type="checkbox"/> _____ _____	<input type="checkbox"/> _____ _____
Age / Date of Birth		
H.K.I.C. No.		
Nationality		
Use of language		
Year arrived in HK		
Tel. No. (Home) (Office) (Mobile Phone)	_____ _____ _____	_____ _____ _____
Home Address		
Education Level		
Occupation		
Year of Marriage / Cohabitation	(Year, e.g. 2000)	
Date of Separation / Divorce (if applicable)	(Year/month, e.g. 2000/01)	
Health and Emotion condition (Please specify any disability, physical injuries, chronic illness, suicidal ideation, emotional problem and current condition)		
Remarks (Please specify other relevant information)		

**2. Family Composition** (i.e. children and other significant family members living with father and mother)

	Name (Both English and Chinese)	Relationship with [*e.g. son/daughter (close/fair/detached)]		Sex	Age / D.O.B.	Education / Occupation (Position)	Living with (Please 「ü」 wherever applicable)			Remarks (e.g. any disability, health/behavioural problem, special needs etc.)
		Father	Mother				Father	Mother	Others (pls specify)	
1.		Son (fair)	Son (close)							
2.										
3.										

**3. Brief History of Parents' Relationship** (please put a 「ü」 in )

3.1 Major Reason(s) for *Separation / Divorce	
3.2 Filing of Divorce Petition	<input type="checkbox"/> Yes <input type="checkbox"/> No
3.3 *Domestic Violence / Suspected Child Abuse (the latest incident/weapon used/MDCC held, if applicable)	<input type="checkbox"/> Yes <input type="checkbox"/> No Date/Event/*DV/Suspected Child Abuse incident: _____
3.4 Risk Level assessed by Referrer	<input type="checkbox"/> High <input type="checkbox"/> Moderate <input type="checkbox"/> Low
3.5 Intensity of Conflict between both parents	<input type="checkbox"/> High <input type="checkbox"/> Moderate <input type="checkbox"/> Low (please specify the major conflict: _____ _____)

\* Delete as appropriate

**4. Perception/Attitudes towards the arrangement of co-parenting service**

	Acceptance Level	Remarks
4.1 Father	<input type="checkbox"/> Low <input type="checkbox"/> Moderate <input type="checkbox"/> High	
4.2 Mother	<input type="checkbox"/> Low <input type="checkbox"/> Moderate <input type="checkbox"/> High	

**5. Recommended Services**

- Co-parenting counseling
- Parenting Co-ordination Service (consent of **both** parents required)
- Child Contact/Exchange Service (consent of **both** parents required)
- Counselling on children's emotion and adjustment towards parental separation (consent of both parents is preferable)
- Groups/programmes/workshops

**6. Consents Given by Parents**

- 6.1 By father:  Yes  No  
 6.2 By mother:  Yes  No

**7. Supplementary Information (if any):**

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Signature of Referrer :

Signature of Supervisor:

Name & Post

Name of Supervisor :

Tel. No. :

Date :

Date :