

The Three-tier School-based Emergency Mechanism

Referral of student to receive psychiatric services of the Hospital Authority

Designated School Principal Referral Form (Applicable from December 2025)

Our school _____ (Name of School) would like to refer _____ (Name of Student) _____ (ID No.) who is currently studying in _____ (Class) to receive psychiatric services of the Hospital Authority (HA). Please arrange risk assessment and follow-up services for this student as soon as possible.

I. **Reason(s) for referral to the third-tier support services:** *(Please select one of the following options)*

- ☐ High suicidal risk
- ☐ High suicidal risk, and with other severe mental health need(s)

Related information on reason(s) for referral: *(e.g. related suicidal ideation/ threat/ attempt, psychological and mental state, behaviour)*

- History of suicidal ideation/ threat/ attempt: **[Mandatory]**

Nature	Date	Related information
Suicidal ideation/ threat/ attempt*		
Suicidal ideation/ threat/ attempt*		
Suicidal ideation/ threat/ attempt*		

[*Please delete as appropriate]

- Supplementary information regarding the suicidal risk:

- Supplementary information of the severe mental health need(s):

II. The first and / or second-tier support services which the student has received in relation to the above referral reason(s) (including services within schools or outside schools, such as assessment or support services by school social worker and school-based educational psychologist): (May choose more than one option)

☐ Utilisation of the first-tier support services:

☐ Individual interview:

☐ Group training:

☐ School-based support and activities:

☐ Others, please specify:

☐ Utilisation of the second-tier support services:

☐ Services of “off-campus support network”:

☐ Services of “Student Mental Health Support Scheme”:

☐ Others, please specify:

III. To the school's knowledge, other medical services that the student has received or is currently receiving / has been referred to in relation to the above referral reason(s) (such as private psychiatrist and clinical psychologist): *(Please select one of the following options)*

☐ No

☐ Yes, please specify:

☐ Not sure

IV. Contact Information:

	School Personnel	Parent / Guardian*
Name:		
Post / Relationship:		
Phone number:		

[*Please delete as appropriate]

[Remarks: If the student's situation is urgent, the school may consider taking the student to the Accident and Emergency Department for treatment.]

Signature of Principal:

Date:

Name of Principal:

School Chop:

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