**TOOL 3.2.3** SAMPLE ONLY REFERRAL FORM[[1]](#footnote-1)

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| The purpose of this document is to refer a client/survivor to a receiving agency, based on their most immediate needs. The referral takes place after informed consent has been given by client/survivor/caregiver. | |
| **Case Risk Level:**  **High: Reason:**  **Medium: Reason:**  **Low: Reason:** | |
| **REFERRING AGENCY** | |
| National Society Name/Operation Name | Contact: |
| Phone: | E-mail: |
| Location: | |
| **RECEIVING AGENCY** | |
| Agency/Organisation | Contact (if known): |
| Phone: | E-mail: |
| Location: | |
| **CLIENT INFORMATION** | |
| Informed Consent given for referral: |  |
| Area of abode: | Sex: |
| Age: | Nationality: |
| Language: | Phone number:  Alternate phone number: |
| Disability:  None  Hearing impairment  Vision impairment  Communication impairment  Ambulatory difficulty  Self-care difficulty  Independent living difficulty |  |
| Name of primary caregiver: | Relationship to child or dependent: |
| Consent given by Caregiver  **1** Yes  **2** No  **3** Not sought due to safety risk |  |
| Contact information for caregiver: | Is child separated or unaccompanied? Yes/No |
| Caregiver is informed of referral  (if no, please explain): |  |
| **BACKGROUND INFORMATION/REASON FOR REFERRAL**  **(PROBLEM DESCRIPTION, DURATION, FREQUENCY, ETC) AND SERVICES ALREADY PROVIDED** | |
| Has the client been informed of the referral? | Has the client been referred to any other organisation? |
|  | |
| **SERVICES REQUESTED** | |
|  | |
| **Informed Consent to Release Information (read with client/caregiver (or trusted adult - if no caregiver or not in the child's best interests, other trusted adult or caseworker) and answer any questions before s/he signs)**  I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(client name), understand that the purpose of the referral and of disclosing this information to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(receiving agency) is to ensure the safety and continuity of care among service providers seeking to serve the client. The service provider, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (referring agency), has clearly explained the procedure of the referral to me and has listed the exact information that is to be disclosed. By signing this form, I authorise this exchange of information. | |
| **Signature/thumb print of responsible party (Client or Caregiver if a minor):** | |
| **Date (DD/MM/YY):** | |
| **DETAILS OF REFERRAL** | |
| Any concern or restrictions | |
| Referral delivered via: | |
| Follow-up expected via: | |
| Information agencies agree to exchange in follow-up | |
| Name and signature of recipient: |  |
| Date received: |  |

1. Adapted from Inter-Agency Standing Committee Reference Group for Mental Health and Psychosocial Support in Emergency Settings: “Inter-Agency Referral Form and Guidance Note” [↑](#footnote-ref-1)