**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** |
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| **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)