Regional Refugee Response for the Ukraine Situation

BULGARIA
INTER-AGENCY REFERRAL FORM

Priority:	Referred via:	Referral Date:	Code
☐ High (*Follow up requested within 24 hours*) ☐ Medium (*Follow up within 3 days*) ☐ Low (*Follow up within 7 days*)	☐ Phone (High priority only) ☐ Email (encrypted) ☐ In Person		

Referred By:	Referred to:
Agency: Name: Position: Contact (Phone/Email): Location :	Agency: Name: Position: Contact (Phone/Email):

Client Information (All personal information is OPTIONAL depending on level of detail the client consents to disclose)

Name:	DOB:	ID No.:
Address/Location:	Sex/Gender:	
Phone:	Nationality:	
	Language:	

If Client Is a Minor (under 18)

Name of primary caregiver: Contact information for caregiver:
Relationship to child:

Caregiver is informed of referral? ☐ Yes ☐ No (If no, explain)

SPECIFIC NEEDS (ONLY INCLUDE INFORMATION WHICH IS RELEVANT TO THE RECEIVING AGENCY)

- ☐ **Child At Risk**
- ☐ **Woman At Risk**
- ☐ **Elderly At Risk**
- ☐ **Single Parent**
- ☐ **Survivor of GBV (incl. sexual abuse and exploitation)**
- ☐ **Person with Disability**
- ☐ **Serious Medical Condition**
- ☐ **Specific Legal or Physical Protection Need**
  - ☐ At risk of physical/psychological abuse, neglect or exploitation
  - ☐ Detained/held in country of asylum
  - ☐ At risk of removal
- ☐ **Other Legal Aid/Advocacy, Registration**

Other family members with specific needs

	Name	Specific need	Relationship
01			
02			
03			

Background Information/Reason for Referral: (problem description, duration, frequency, etc.)

Services already provided: (include any other referrals made)

Agency	Support provided	Date (incl. ongoing)

Services Requested (Indicate priority 1, 2, 3 etc.)

☐ Health	☐ Mental Health and Psychosocial Support	☐ Protection	☐ Education
☐ Material assistance	☐ Home visit or Assessment	☐ Livelihoods	☐ Legal Assistance
☐ Financial assistance	☐ Food assistance	☐ Child Protection	☐ Other

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Specify:

Consent to Release Information (Read with the individual and answer any questions before s/he signs below)

I, (name), understand that the purpose of the referral and of disclosing this information to (referral agency) is to ensure the safety and continuity of care among service providers seeking to serve this family. 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 authorize this exchange of information.

Signature of Responsible Party: Name of individual or Caregiver if a minor) Date:

Details of Referral:

Individual has been informed of referral? ☐ Yes ☐ No (If no, explain)
Individual has signed consent to release information? ☐ Yes ☐ No (If no, explain)
Any contact or other restrictions? ☐Yes ☐No (If yes, explain)
Referral accepted? ☐ Yes ☐ No (If no, explain)
Referral response required? ☐ Yes ☐ No

Receiving Organization:

Referral received by:	Response provided to referring agency by:
Date:	Date:

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