INTER-AGENCY REFERRAL FORM

CONFIDENTIAL: Please restrict access to this document and keep it stored safely.

Note: Please share the filled-out referral form with the person/case and receiving agency and keep a copy for the organization's internal records and follow-up.

Referring agency	
Agency/organization:	Name of the Staff:
Phone:	Email:
Location:	Date of referral:

Receiving agency	
Agency/organization:	Name of the Staff:
Phone:	Email:
Location:	

Case information	
Name:	Phone:
Address:	Age:
Gender:	Nationality:
Main language spoken at home: Other languages the survivor is comfortable speaking and receiving information in:	ID number:
If the person/case is a child (under 18)	
Name of primary caregiver:	Relationship to child:
Contact information for caregiver:	Is child separated or unaccompanied? ☐ Yes ☐ No
Caregiver is informed about referral? ☐ Yes ☐ No (If no, explain)	

Background Information/Reason for referral and services already provided	
Has the person/case been informed of the referral? ☐ Yes ☐ No (If no, explain below)	Has the person/case been referred to any other organization or received any other services? ☐ Yes ☐ No (If yes, explain below)

Services requested		
☐ Mental Health Services	☐ Protection Services	☐ Shelter
☐ Psychosocial Support	☐ Legal Assistance	☐ Transportation
☐ Social Services	☐ Education	☐ Cash/Material Assistance
☐ Medical Care	☐ Livelihood Support	☐ Nutrition
Please explain any requested services:		

Consent to release information. (Read with survivor/ caregiver and answer any questions before s/he signs below. Sign on behalf of person of concern/caregiver if consent is given verbally and survivor/caregiver cannot sign.)
I, _____**(person/ case name),** understand that the purpose of the referral and of disclosing this information to _____(**name of receiving agency**) is to ensure the safety and continuity of care among service providers seeking to serve the client. The service provider, _____ (**name of 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 (survivor or caregiver if a child):
Date (DD/MM/YY):

TO BE FILLED OUT IF THE PERSON/ CASE IS A CHILD OVER 14 (UNDER 18)
Assent to release information. (Read with person/case or caregiver and answer any questions before s/he assents, additional to caregiver's above consent. Sign on behalf of person/case or caregiver if consent is given verbally and survivor/caregiver cannot sign.)
I, _____**(person/case name),** understand that the purpose of the referral and of disclosing this information to _____(**name of receiving agency**) is to ensure the safety and continuity of care among service providers seeking to serve the client. The service provider, _____ (**name of 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.
Date (DD/MM/YY):

Details of Referral

Any contact or other restrictions? ☐ Yes ☐ No (If yes, please explain below)
Referral delivered via: Phone (emergency only) ☐ E-mail ☐ Electronically (e.g., App or database) ☐ In Person
Follow-up expected via: ☐ Phone ☐ E-mail ☐ In Person. By date (DD/MM/YY):
Information agencies agree to exchange in follow up:

When form is received via email, please respond with acknowledgment of receipt and intake of the case.

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