

# REFERRAL FORM

Referral Date \_\_\_\_/\_\_\_\_/\_\_\_\_

## Client Information

First name: \_\_\_\_\_

Surname: \_\_\_\_\_

Gender:  Male  Female

Date of Birth (dd/mm/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_

Address \_\_\_\_\_

Contact number: \_\_\_\_\_

Country of Origin: \_\_\_\_\_

UK arrival date (dd/mm/yyyy) \_\_\_\_/\_\_\_\_/\_\_\_\_

Preferred Language: \_\_\_\_\_

Interpreter required?  Yes  No

Preferred gender?  Male  Female  N/A

## Reason(s) for Referral (check all that apply)

- Therapeutic Care/Counselling     Medical report     Other \_\_\_\_\_

**Any urgent factors to be considered** (eg levels of trauma being exhibited, hearing date, fast track etc)

## Your client's experiences of human rights violations. Please check *all* that apply.

- |  |  |
|--|--|
| <input type="checkbox"/> Assault                                     | <input type="checkbox"/> Religious Persecution             |
| <input type="checkbox"/> Child Soldiers                              | <input type="checkbox"/> Sexuality Based Persecution       |
| <input type="checkbox"/> Domestic/Family Violence                    | <input type="checkbox"/> Slavery                           |
| <input type="checkbox"/> Ethnic/Racial/Social Persecution            | <input type="checkbox"/> Solitary Confinement              |
| <input type="checkbox"/> Female Genital Mutilation                   | <input type="checkbox"/> Torture (State sponsored)         |
| <input type="checkbox"/> Forced Marriage                             | <input type="checkbox"/> Torture (Non-state sponsored)     |
| <input type="checkbox"/> Gang based/Inter-tribal/Inter-clan violence | <input type="checkbox"/> Trafficking (Sexual exploitation) |
| <input type="checkbox"/> Honour Killings (Threatened/Attempted)      | <input type="checkbox"/> Trafficking (labour exploitation) |
| <input type="checkbox"/> Political Persecution                       | <input type="checkbox"/> Violations of Liberty             |
| <input type="checkbox"/> Rape  | <input type="checkbox"/> Witness to Atrocity               |

Other/Comments \_\_\_\_\_

## Please provide a brief history of your client's experiences of human rights violations:

**Asylum Status (if applicable)**

- |   |   |
|---|---|
| <input type="checkbox"/> ILR (Refugee Status)     | <input type="checkbox"/> Appeal Decision Pending  |
| <input type="checkbox"/> ILR (Legacy Case)        | <input type="checkbox"/> Appeals Rights Exhausted |
| <input type="checkbox"/> Refugee Status           | <input type="checkbox"/> Fresh Claim              |
| <input type="checkbox"/> Discretionary Leave      | <input type="checkbox"/> Detained Fast Track      |
| <input type="checkbox"/> Humanitarian Protection  | <input type="checkbox"/> Unknown                  |
| <input type="checkbox"/> Initial Decision Pending | <input type="checkbox"/> Other _____              |

Comments \_\_\_\_\_

**Social Support**

- |   |  |
|---|--|
| <input type="checkbox"/> NASS Section 95                          | <input type="checkbox"/> Social Services (other)             |
| <input type="checkbox"/> NASS Section 4                           | <input type="checkbox"/> Social Services (UASC/Section17/20) |
| <input type="checkbox"/> Destitute (friends and family/community) | <input type="checkbox"/> Refugee Status (working)            |
| <input type="checkbox"/> Destitute (street homeless)              | <input type="checkbox"/> Refugee Status (benefits)           |
| <input type="checkbox"/> Section 21                               | <input type="checkbox"/> Student Funds                       |

Other/Comments \_\_\_\_\_

**Family Members**

Name	D.O.B.	Relationship	Gender	Location

**Other referrals made?**

- |   |  |
|---|--|
| <input type="checkbox"/> Medical Foundation       | <input type="checkbox"/> CMHT          |
| <input type="checkbox"/> Medical Justice          | <input type="checkbox"/> Poppy Project |
| <input type="checkbox"/> Traumatic Stress Service | <input type="checkbox"/> Other _____   |

**Outcome of referral?**

- |                                       |                                      |
|---------------------------------------|--------------------------------------|
| <input type="checkbox"/> Accepted     | <input type="checkbox"/> Pending     |
| <input type="checkbox"/> Not Accepted | <input type="checkbox"/> Other _____ |

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## Detention History (current or previous)

Name of Immigration Centre:

Arrival Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Release Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

## Healthcare and Well-Being

Please describe the major presenting problems as described by your client, including their severity.

		<i>Internal use only</i>
Medical/Physical		
Psychological		
Social		
Other		

Does your client have access to healthcare? Y N

Are the client's healthcare services meeting his or her needs? Y N

Any previous Medical Reports completed for your client? \_\_\_\_\_ (If yes, please attach.)

Details of involvement with other health services:

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**Contact Information****Medical**

GP Name:	
Firm/ Practice:	
Address:	
Phone:	Fax:
Email address:	

**Referrer**

Name:	
Firm/ Organization:	
Address:	
Phone:	Fax:
Email address:	

**Solicitor** (if different from Referrer)

Name:	
Firm/ Organization:	
Address:	
Phone:	Fax:
Email address:	

***Please fill out the above information as completely as possible. This will aid us in responding to your referral as promptly as possible. If available please attach SEF, interview records, statement, reason for refusal letter, determinations and any relevant medical information. Please note, if relevant documents are not enclosed, this will cause a delay in the consideration of the referral. If you do not have access to these documents please explain why here:***

***Please send completed form to Matthew McDonnell by fax: 0207 631 4493  
by post: Helen Bamber Foundation, 5 Museum House, 25 Museum Street, London WC1A 1JT  
or email: matt@helenbamber.org***