REFERRAL PROCEDURE

Before SAFOD refers a survivor, they should:

- Ensure that survivor understand next steps after incident report.
- Get consent form the survivor to be referred-work with survivor on choosing the best services for them i.e., the organization should provide a list of service providers and give to survivor so they chose for themselves after giving information about them.
- Fill out a referral form and assist survivor in reaching the service provider.
- Keep all information confidential at all times

REFERRAL FORM

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

Note: Please share copies of filled out referral forms with the survivor and receiving agency and keep acopy for the organization's internal records and follow-up.

Referring organization	
Agency/org:	Contact:
Phone:	Email:
Location	

Receiving organization	
Agency/org:	Contact:
Phone:	Email:
Location	

Survivor information	
Name:	Phone:
Address:	Age:
Sex	Nationality:
Language:	ID number
If survivor is a minor (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 survivor been informed of the referral? ☐ Yes ☐ No (If no, explain below)	Has the survivor been referred to any other organization?

	c Yes No (If yes, explain below)

Services requested		
Mental Health Services	Protection Services	Shelter
Psychosocial Support	Legal Assistance	Material Assistance
Social Services	Education	Nutrition
Medical Care	Livelihood Support	Support for children born as aresult of SEA
Please explain any requested services:		

Consent to release information. (Read with survivor/ caregiver and answer any questions before s/he signsbelow. Sign on behalf of survivor/caregiver if consent is given verbally and survivor/caregiver cannot sign.)
I,_____**(survivor 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 ofcare 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 informationthat 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):

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) InPerson
Follow-up expected via: Phone E-mail In Person. By date (DD/MM/YY):
Information agencies agree to exchange in follow up:

Name and signature of recipient: Date received (DD/MM/YY):