

MEDICAL FOUNDATION REFERRAL FORM

Please note this form is not to be used for referrals for Medico-Legal Reports

Date of referral: _____

INFORMATION ABOUT THE CLIENT

Family name: _____

Title: _____

First name: _____

Sex: Male ☐ Female ☐

Date of birth: (indicate if Unknown) _____

Religion _____

Place of birth: _____ **Nationality:** _____

Ethnic Origin _____

Need for interpreter: ☐ YES Language(s) _____

☐ NO - Client is happy for service to be in English

Current address:

Address _____

Town: _____

Post Code: _____

Telephone: _____

Mobile: _____

Email: _____

Or, where should appointment be sent? (e.g. solicitor, by phone, etc.)

Name _____

Address: _____

Town: _____

Post Code: _____

Telephone: _____

Mobile: _____

Email: _____

INFORMATION ABOUT THE REFERRER

Name of Referrer: _____

Title: _____

Role: _____

Organisation: _____

Address: _____

Post Code: _____

Telephone: _____ Fax: _____

Email: _____ Mobile: _____

Preferred means of communication: _____

CLIENT'S STATUS

Date of arrival in the UK: _____

Status (please tick boxes and provide as much detail as possible):

☐ Seeking Asylum. What stage? _____

☐ Granted Asylum. When? _____ How long for? _____

☐ UK Citizen ☐ Other _____

Please provide details if specific circumstances and difficulties in relation to the Client's status:

Legal Representative

Name _____

Firm: _____

Address: _____

Town: _____

Post Code: _____

Telephone: _____

Mobile: _____

Email: _____

GP

Name _____

Practice: _____

Address: _____

Town: _____

Post Code: _____

Telephone: _____

Mobile: _____

Email: _____

CLIENT'S BACKGROUND AND HISTORY

Please provide details of client's life prior to arriving in the UK, including history of torture and persecution: (please provide as much details as you can about the nature of the torture, when it occurred, over how long a period. This information will help us process this referral quickly and appropriately)

CLIENT'S CURRENT DIFFICULTIES (please give as much detail as possible, this information may help us decide how we can best help the client)

- Psychological

- Physical

- Adjustment to life in the UK

- Social and welfare (e.g. finance/benefits, housing)

CLIENT'S FAMILY: (Please provide family details, specifying whereabouts of family members and nature of relationships with the client)

CLIENT'S SOCIAL NETWORKS: (Please provide details of client's social networks and activities (eg community, religious, educational, vocational) and the level of the client's engagement)

OTHER AGENCIES INVOLVED IN CLIENT'S CARE: (Please provide details of statutory or non-statutory organisations that the client is involved with e.g. Community Mental Health Team, Refugee Community Organisation):

Organisation: _____

Name of Designated worker: _____

Address: _____

Town: _____

Post Code: _____

Telephone: _____

Mobile: _____

Email: _____

Nature of involvement: _____

Organisation: _____

Name of Designated worker: _____

Address: _____

Town: _____

Post Code: _____

Telephone: _____

Mobile: _____

Email: _____

Nature of involvement: _____

Other Referrals: Has the client been referred elsewhere, if so, where?

What are the expectations from this referral? The referral is for work with:

☐ Adult ☐ Family ☐ Couple ☐ Child

- In what ways would you expect the Medical Foundation to help the client?

- What are the Client's expectations?

- What is the level of Client's involvement in the referral?

- Please give details of others involved in the referral process (eg Interpreter, family members, friends, etc)

Any other information: Is there anything else you think we should know about the client?

Client's Signature: _____ Date: _____

Referrer's Signature: _____

Date: _____