ANNEX N: Referral Form for Referring Agency Copy

This is a tool referenced in the Tools for Establishing Referral Pathways section of Chapter 6: ASRH Services & Interventions. The Inter-Agency Standing Committee (IASC) provides standard forms for making referrals for mental health and psychosocial support (MHPSS) cases across all humanitarian sectors. The Toolkit has adapted these forms for referring adolescent clients to different services between sectors, such as nutrition, gender-based violence (GBV), water, sanitation, and hygiene (WASH), etc. These include forms for the agency making the referral, the client receiving the referral, and the agency receiving the referral request. This tool is specifically a referral form for the referring agency.

Referring Agency copy ☐ Routine ☐ Urgent Date of Referral (DD/MM/YY): _____

Multi-Sector Referral Form for Adolescent Clients

Referring Agency	
Agency/Org:	Contact:
Phone:	Email:
Location:	

Receiving Agency	
Agency/Org:	Contact (if known):
Phone:	Email:
Location:	

Adolescent Client Information	
Name:	Phone (if available):*
Age:	
Identified Gender:	Address/Location (if available):*
Language:	
Notes:**	

**If the adolescent client is not comfortable sharing this information, it is not required to complete the referral. Use discretion when asking questions and utilize Toolkit resources for talking to adolescents (see Five Principles for Creating a Trustful Atmosphere for Adolescent Counseling).*
***Use this space for including any additional information necessary and/or useful for the receiving agency, such as capacities of the adolescent client that may affect their ability to access or receive the SRH services (e.g. cognitive impairments, physical disabilities, etc.)*

Background Information/Reason for Referral: problem description, duration, frequency, etc. and services already provided	
Has the adolescent client been informed of the referral? ☐ Yes ☐ No* (if no, explain below)	Has the adolescent client been referred to any other organizations? ☐ Yes* (if yes, explain below) ☐ No

**Use this space if the client did not consent for referral due to being unconscious and in need of emergency life-saving services.*

Consent to Referral & Release Information (read with adolescent client and answer any questions before they sign below)
I,_____ (adolescent client name), understand that the purpose of the referral and sharing this information with _____ (receiving agency) is to ensure my safety and to make sure I receive the services I need. 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 shared. By signing this form, I authorize this referral and exchange of information.
Signature of Adolescent Client:
Date (DD/MM/YY):
If required by local laws,* signature of Adolescent Caregiver:
Date (DD/MM/YY):

**Providers and referring agencies should document consent to the full extent of local laws. If no policy exists regarding consent, international standards for documenting consent should be adhered to. [Note: International Standards do not require consent from an adult to receive services.] Refer to Facility-Based Services and Data for Action sections on consent and assent to find more detailed guidance.*

Services Requested*		
☐ General health services	☐ Camp management services	☐ Food & Livelihoods services
☐ SRH services	☐ Cash & voucher assistance services	☐ Legal assistance services
☐ GBV services		☐ Shelter services
☐ MHPSS services	☐ Child protection services	☐ WASH services
☐ Nutrition services	☐ Education services	☐ Other (please explain below)
Please explain any requested services:		

**Some referrals may have overlapping services and/or may not be available in all contexts. Check all relevant boxes.*

Details of Referral			
Does the adolescent client consent to follow-up communications after their referral visit? ☐ Yes ☐ No If yes, what mode of communication does the adolescent client prefer? (explain below)			
Referral delivered for adolescent client via:			
☐ Phone (emergency only)	☐ E-mail	☐ Electronically (eg App or database)	☐ In Person
Follow-up communications expected between referring agencies via:			
☐ Phone	☐ E-mail	☐ In Person	
By date (DD/MM/YY):			
Referring agencies agree to exchange during follow up call/appointment:			

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

Source: Inter-Agency Referral Form and Guidance Note (IASC Reference Group for Mental Health and Psychosocial Support in Emergency Settings, 2017).