**Inter-Agency Referral Form**

**Ukraine**

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| **Priority** | | |
| Urgent (within 24 hours) | | Normal (within 3-5 days) |
| **Case information (if consent has been obtained*): Insert the basic biodata and contact information which is needed for the case to access the required service. Check Service Mapping to see if additional requirements are necessary to access the service.*** | | |
| Name (or Case Code if confidential): | | Date of birth: |
| Gender: | | Preferred method of contact: |
| National ID: | | Preferred day/time of contact |
| Address (street/settlement): | | |
| Address 2 (Oblast/Rayon/Territorial community): | | |
| Phone: | | Additional (disability etc.): |
| **If a child (under 18 years old)** *Remember: if it is not appropriate to involve the child’s caregiver (for instance if the caregiver is involved in the abuse), informed assent should be sought from the younger child.* | | |
| Name of primary caregiver: | | Relationship to child: |
| Contact Info for caregiver: | | Is child separated or unaccompanied? Yes No |
| Caregiver is informed of referral? Yes No (If no, explain): | |  |
| Special Note/Specific Need: | | |
| **Reasons for Referral: *Describe the minimum information required by the receiving agency to be able to respond to the referral. This can include problem description, whether they receive other assistance, number in the household, etc. For referrals to GBV, CP and Protection case management, do not provide details of the case or incident.*** | | |
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| **Need for service/assistance** | | |
| Protection | | Health |
| SGBV | | Shelter |
| Child Protection | | Non-Food Items |
| Legal Assistance | | WASH |
| Multi-Purpose Cash | | Nutrition |
| Education | | Other |
| Food Security and Livelihoods | |  |
| Please explain any need for service, and any already provided: | | |
| **Consent to Release Information** *(read with client/caregiver and answer any questions before s/he signs below)* | | |
| I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (person of concern name), acknowledge that the service provider, \_\_\_\_\_\_\_\_\_\_\_\_\_  (service provider name) has clearly explained the procedure of the referral to me and has listed the exact information  that is to be disclosed. I understand that my information will be treated with confidentiality and respect, and will only  be shared as needed to provide assistance and may be used for purposes of humanitarian analysis. By signing this  form, I authorize this exchange of information to the specific service provider/s for the specifi­c purpose of providing  assistance to my family and/or myself. | | |
| **Signature (or caregiver if child):** | | **Date:** |
| **Referred By: Referred To:** | | |
| Name: | | Name: |
| Sector of operation: | | Sector of operation: |
| Agency: | | Agency: |
| Contact Info: | | Contact Info: |
| Date of Referral: | Delivered via: Phone (emergency only) E‐mail (encrypted) In Person (sealed envelope) | |
| Any contact or referral restrictions? | No Yes (specify any or all): | |