**Client Referral Form**

## PO Box 151240

San Diego, CA 92175-1240

Main Number: (619) 278-2400 | Facsimile: (619) 294-9405 | Email: survivors@notorture.org

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|  **REFERRER**  |
| **Referred By:**  | **Date: Click here to enter a date.** |
| **Agency/Office Address:**  |
| **City:**  | **State:**   | **Zip:**  |
| **Phone:**  | **Fax:**  | **Email:**  |
| **I wish to refer the person below for the following services (select one or more specific to this case) :** |
| ☐Psychological Evaluation for Asylum | ☐Medical Evaluation for Asylum | ☐Counseling |
| ☐Social Service Case Management | ☐Medical Case Management | ☐Psychiatry/Medication Management |

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| **If this request involves immigration proceedings, please note the average time to coordinate forensic evaluation is 30-45 days. When requesting evaluations, please also submit client’s declaration (in English).** |
| **Last date attorney can accept final report:** Click here to enter a date. |

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|  **PERSON BEING REFERRED**  |
| **Last Name:**  | **First Name:**  | **Middle Name:**  |
| **Primary Phone:**  | **Secondary Phone/Email:**  |
| **Address:**  | **City:**  | **State:**  | **Zip:**  |
| **Gender:** Choose an item. | **Country of Origin:**  | **Ethnicity:**  | **Religion:** |
| **DoB:**  | **Current Age:**  | **Marital Status:** Choose an item. |
| **Date of Entry into U.S.:** | **Legal Status (must attach declaration for asylum seekers) :** Choose an item. |
| **Language(s):**  | **Does this client speak English?**Yes No SomeChoose an item. | **Alien#:**  |
| **SS#:**  |
| Brief description of the alleged torture: Click here to enter text.  | Brief description of the psychological effects of alleged torture:Click here to enter text.  |
| Brief description of the medical effects of alleged torture:Click here to enter text.  | Reported reason for torture:  |
| Reported perpetrators of torture:  |
| [SURVIVORS use only] Client ID: | Country(ies) where torture occurred: |

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