1. **CASE INFORMATION**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Date of referral dd/mm/yyyy | | Case ID number dd/mm/yyyy | | |
| Consent or assent provided for referral | * Yes | | * No | * Not applicable |

1. **REFERRAL INFORMATION**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Type of referral | | * Internal referral | | | * External referral | | |
| Referred through –  **please avoid editing dropdown** | | * Phone (high risk cases only) * CPIMS+ or digital case management system | | | * Email (protect the document with password) * In person (in sealed envelope) * Other, specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| Referred **FROM:** | | | | Referred **TO:** | | | |
| Name agency/organization |  | | | Name agency/organization | | |  |
| Sector (if applicable) – **please avoid editing dropdown** | * Education * Food security * Health * Livelihoods * Nutrition * Protection * Child Protection * GBV * Shelter * Camp Cord and Camp Mgmt * Water, sanitation, and hygiene (WASH) * Other \_\_\_\_\_\_\_\_\_\_\_\_ | | | Sector (if applicable) -  **please avoid editing dropdown** | | | * Education * Food security * Health * Livelihoods * Nutrition * Protection * Child Protection * GBV * Shelter * Camp Cord and Camp Mgmt * Water, sanitation, and hygiene (WASH) * Other \_\_\_\_\_\_\_\_\_\_\_\_ |
| Name focal point |  | | | Name focal point | | |  |
| Position focal point |  | | | Position focal point | | |  |
| Address agency/ organization |  | | | Address of agency/organization | | |  |
| Email address of focal point |  | | | Email address of focal point | | |  |
| Telephone of focal point |  | | | Telephone of focal point | | |  |
| How the will caseworker follow-up on the referral | | | * Phone (high risk cases only) * Face-to-face meeting with service | | | * Email (protect the document with password) * Other, specify \_\_\_\_\_\_\_\_\_ | |

1. **SERVICE(S) REQUESTED**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Urgency of service requested | | * High (to respond as soon as possible and within 24 -48 hours) | | | * Medium | | * Low |
| Type of service requested –  **please avoid editing dropdown** | * Health services * Nutrition services * Food security services * Livelihood services * Cash assistance services | | * Mental health and psycho-social support services * Family Tracing and Reunification services * GBV services * Alternative care services * Documentation and civil registration * Legal and justice services | | | * Education services * Shelter services (not places of care) * Water, sanitation and hygiene services * Specialized services for children with disabilities | |
| Description of the needs  *(Describe the needs, relevant services already provided or interventions undertaken, and any other relevant details for the service provider.)* | | | | Expected outcome of the service requested  *(Describe what you and the person being referred is hoping to achieve through the referral)* | | | | |

1. **CASE PERSONAL DETAILS**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| First name | | *(Optional) Middle name / Father's name* | | | Last Name/ Family Name | | | Other names or spelling of name the person is known by |
| Date of birth (DOB)  dd/mm/yyyy  Age \_\_\_\_\_\_\_\_, is the age is estimated   * Yes * No | | | Sex **- please avoid editing dropdown**   * Male * Female * Non-binary * Other | | Nationality (create options for your context) | | ID Type   |  | | --- | |  |   ID Number   |  | | --- | |  | | |
| Current Address | | | How can the child be contacted?  If not directly, specify through who | | | | If available, include phone number *(indicate If this is WhatsApp, Viber etc.)* | |
| Languages spoken by the child (create options for your context) | | | | | | | | |
| Disability status - **please avoid editing dropdown** | * No disabilities | | | | | * Child with disabilities (*mark below if possible*) * Mental impairments * Sensory impairments * Physical impairments * Intellectual impairment * Other, specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| Any other relevant information to facilitate access or tailor support  *(For example if, child has difficulty climbing stairs, preference for female focal point to do intake, etc.)* | | | | |  | | --- | |  | | | | | |

1. **AUTHORIZATION**

|  |  |  |
| --- | --- | --- |
| Caseworker name | Date dd/mm/yyyy | Signature |