SPIRASI
Initial Assessment Referral Form

To be completed by a Health Professional to request an **Initial Assessment** which includes medical, psychotherapeutic and psychosocial assessment.
Please ensure form is completed clearly, giving as much information as possible.

1. Personal Details of Client: (in BLOCK CAPITAL please)

First Name:	Family Name:
Gender: Male □ Female □	Current address:
Date of Birth:	
Country of Origin:	
Native language(s):	Telephone No:
Separated Child (unaccompanied): Yes □ No □	E-mail:
Marital Status:	Person Identity No:
Number of dependants in Ireland:	PPS No:
Number of dependents in Country of Origin:	Medical Card No:
Interpreter Required: Yes □ No □ If YES, which language(s):	

2. Residency Status: (Please tick the relevant box.)
Asylum Seeker □ Refugee □ Other (please specify): _____

3. Details relating to detention and/or ill-treatment:
(Please ensure all information relating to claims of torture, degrading and inhuman treatment is documented)

a. Detention in country of origin:

Arrested and/or detained? Yes □ No □ How many times arrested/detained? _____

When? Year _____ Month _____ For how long in total? _____

Where? Country: _____ Facility: _____

Why? _____

b. Nature of claimed torture/inhuman or degrading treatment:

1. Beating □ With what? _____

2. Kicking □ Type of footwear? _____

3. Cuts □ 4. Burns □ 5. Suspension □ 6. Suffocation □ 7. Submersion □ 8. Electric Shock □

9. Toe/fingernail removal □ 10. Sexual Assault □ 11. Rape □ 12. Solitary confinement □

13. Other (please specify) _____

Who carried out the above? _____

Why?_____

4. Current situation:

Please give a brief description of…

a. Current psychological & physical symptoms:

_____

_____

_____

b. Any Treatment received / receiving in Ireland:

_____

_____

c. Current medication:

_____

_____

5. Assistance Requested:

In what way do you think SPIRASI may be able to assist your client?

_____

_____

6. Name of Referrer: _____

7. Please tick relevant box: **GP** □ **AMO** □ **Other:** _____

Your Contact Details: **(in BLOCK CAPITALS or official stamp please)**

Name:	
Address:	**Phone No:**
	Fax No:
	E-mail:

>> N.B. SPIRASI WILL NOT SEE CLIENT UNLESS THEY ARE REGISTERED WITH A GP <<

Referrer's Signature: _____ **Date:** _____

Please return or contact for enquiries:

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