TRAUMA-INFORMED ABORTION CARE:

Confidential Consent for Release of Information and Referral Form

This form should be described to the client (or guardian with the client's approval) in their primary language. Sections A-C contain background information likely given during your consultation. Sections D-F should be read and fully explained and discussed with the client to fully ensure that they agree to proceed and that you are able to ensure confidentiality and security. It should be clearly explained to the client that they can choose any or none of the options listed and that they can change their mind at any point in the process.

☐ Routine ☐ Urgent Date of Referral (DD/MM/YY): .....

A. Your referring facility /agency	
Agency/Organization:	Contact:
Phone:	Email:
Location:	

B. Client information	
Name:	Phone (if available):*
Age:	Address/Location (if available):*
Identified Gender:	
Language:	
Notes:**	

* If client is not comfortable sharing this information, it is not required to complete the referral. Use discretion when asking questions and utilize counseling resources for talking to clients effected by trauma.

** Use this space for including any additional information necessary and/or useful for the receiving agency, such as capacities of the client that may affect their ability to access or receive services (e.g. cognitive impairments, physical disabilities and so on.)

C. Background Information/Reason for Referral	
Has the client been informed of the referral? ☐ Yes ☐ No* (if no, explain below)	Has the client been referred to any other organizations? ☐ Yes* (if yes, explain below) ☐ No
Background, services provided and reason for referral. **Please ensure the client is comfortable sharing and having this in writing.**	

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

D. Consent to Referral & Release Information (Please read with client and answer any questions before they sign below)
I, _____ (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. I understand that shared information will be treated with confidentiality and respect and shared only as needed to provide the assistance I request. I understand that releasing this information means that a person from the agency or service ticked below may come to talk to me. At any point, I have the right to change my mind about sharing information with the designated agency / focal point listed below.
Signature of Client:
Date (DD/MM/YY):
If required by local laws,* signature of Guardian:
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.]

E. Services Requested*		
General health services	**Receiving Facility/ Agency**	
	Agency/Organization:	Contact (if known):
	Phone:	Email:
	Location:	
SRH services	**Receiving Facility/ Agency**	
	Agency/Organization:	Contact (if known):
	Phone:	Email:
	Location:	
GBV services	**Receiving Facility/ Agency**	
	Agency/Organization:	Contact (if known):
	Phone:	Email:
	Location:	
MHPSS services	**Receiving Facility/ Agency**	
	Agency/Organization:	Contact (if known):
	Phone:	Email:
	Location:	
Food & Livelihoods services	**Receiving Facility/ Agency**	
	Agency/Organization:	Contact (if known):
	Phone:	Email:
	Location:	
Legal assistance services	**Receiving Facility/ Agency**	
	Agency/Organization:	Contact (if known):
	Phone:	Email:
	Location:	
Safe House/ Shelter	**Receiving Facility/ Agency**	
	Agency/Organization:	Contact (if known):
	Phone:	Email:
	Location:	

Protection services	**Receiving Facility/ Agency**	
	Agency/Organization:	Contact (if known):
	Phone:	Email:
	Location:	
Other....	**Receiving Facility/ Agency**	
	Agency/Organization:	Contact (if known):
	Phone:	Email:
	Location:	
Please explain any other requested services:		

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

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

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