Referral Form- Libertas Center for Human Rights Date of Referral: MM/DD/YYYY

*Prospective Client Information*

|  |  |  |  |
| --- | --- | --- | --- |
| First Name | Click here to enter text. | U.S. Date of Arrival  | MM/DD/YYYY |
| Last Name | Click here to enter text. | Work Authorization (Y/N)  |  [ ]  Yes [ ]  No |
| Date of Birth | MM/DD/YYYY | Stable Housing (Y/N) |  [ ]  Yes [ ]  No |
| Country of Origin | Click here to enter text. | Medical Record # (if any) | Click here to enter text. |
| Gender | Choose an item. | Alien # | Click here to enter text. |

*Prospective Client Contact Information*

|  |  |  |
| --- | --- | --- |
| Ok to contact client?  |  [ ]  Yes [ ]  No | Email address Click here to enter text. |
| Phone number | Click here to enter text. | Address Click here to enter text. |
| Client Primary Language | Click here to enter text. | Does client prefer an interpreter? | [ ]  Yes [ ]  No |

 *Referral Source Information*

|  |  |  |  |
| --- | --- | --- | --- |
| Referral Agency | Click here to enter text. | Referral Name & Title | Click here to enter text. |
| Referral Phone | Click here to enter text. | Referral Email | Click here to enter text. |

*Reason(s) for Referral to the Libertas Center (indicate all that apply)*

|  |
| --- |
| [ ]  Medical Care [ ]  Mental Health Care [ ]  Case Management/Social [ ] Legal Services [ ]  Forensic Medical Affidavit [ ]  Forensic Psychological Affidavit Documentation Deadline:\_\_\_\_\_\_\_\_\_\_\_\_ |

 *Prospective Client History*

|  |
| --- |
| Was client harmed? [ ]  Yes [ ]  No Country where harm occurred: Click here to enter text. |
| Where did harm occur? (*Prison/jail, military base, school, home, etc..)* Click here to enter text. |
| Who harmed client? (*government, police, military, gang/militia,, family member, etc..)* Click here to enter text. |
| How was client harmed? *(death threats, beatings, sexual assault, etc..)* Click here to enter text. |
| Month/Year when first subjected to harm: #### |

*Is the client currently receiving any of the following services?*

|  |  |  |  |
| --- | --- | --- | --- |
|  | Name of agency or facility |   | Name of agency or facility |
| [ ]  Legal | Click here to enter text. | ☐ Mental Health | Click here to enter text. |
| [ ]  Medical | Click here to enter text. | [ ]  Case Management/Social | Click here to enter text. |
| [ ]  Other | Click here to enter text. |  |  |
| Has this client been referred to Bellevue’s Program for Survivors of Torture? [ ]  Yes [ ]  No Client’s preferred center for treatment, you must only pick one. No duplicate services available: [ ]  Elmhurst/ Libertas Center (Queens) [ ]  Bellevue/PSOT (Manhattan)  |

*Legal Case*

|  |  |
| --- | --- |
| If you applied for asylum, when did you apply? | MM/DD/YYYY |
| If you have a court hearing, when is the date?  | MM/DD/YYYY |
| Lawyer’s name, phone number, and email | Click here to enter text. |

**Please attach personal statement, I-589, and accompanying country conditions related to persecution history.**