SAO Association Hellas
Women for displaced Women

BASHIRA CENTRE REFERRAL FORM

DATE OF THE REFERRAL:
NAME - ORGANISATION AND CONTACT DETAILS OF THE REFERRER (PHONE NUMBER/EMAIL):

BENEFICIARY INFORMATION	
NAME:	**AGE:**
NATIONALITY:	**LANGUAGE:**
FAMILY STATUS:	**CHILDREN UNDER 2 YEARS:**
ADDRESS:	**PHONE NUMBER:**
Please state if any referrals have already been made to other organizations (safe accommodation, legal aid support,):	
Mental Health diagnosis*:	
Psychiatric medication: YES/NO	

****Please note we are not able to support severe mental health cases (non- stabilized psychiatric cases namely risk of suicidality, active psychotic symptomatology)***

BACKGROUND INFORMATION/ REASON FOR REFERRAL*:

**** Please state any important medical conditions as well as connected medication, if any, that will enable us to react and support in case of emergency (e.g. epilepsy, mental health medication side effects, diabetic woman receiving insulin)***

Consent for release of information
I, _____, (beneficiary's name), hereby give my permission to _____(referring actor) to provide the information in this form to Bashira Centre. I understand that shared information will be treated with confidentiality and respect, and shared only as needed to provide the best assistance. By signing this form, I authorise the exchange of information. Signature: _____ Date: _____