

Referral Form

BOSTON CENTER FOR REFUGEE HEALTH AND HUMAN RIGHTS at Boston Medical Center

Please Fax to Erica Hastings at 617.414.4796

Ph. 617.414.4794 - email. erica.hastings@bmc.org

Date of Referral: _____

MRN (internal): _____

Type of Service Requested:

Appointments Scheduled (Internal)

<input type="checkbox"/> Forensic Medical Evaluation for affidavit	<input type="checkbox"/>
<input type="checkbox"/> Ongoing Medical Care	<input type="checkbox"/>
<input type="checkbox"/> Psychological Evaluation for affidavit	<input type="checkbox"/>
<input type="checkbox"/> Mental Health Treatment	<input type="checkbox"/>
<input type="checkbox"/> Neuropsych Testing	<input type="checkbox"/>
<input type="checkbox"/> Vocational Rehabilitation	<input type="checkbox"/>
<input type="checkbox"/> Case Management	<input type="checkbox"/>
<input type="checkbox"/> Dental Screening	<input type="checkbox"/>
<input type="checkbox"/> Legal Referral	<input type="checkbox"/>

PATIENT/CLIENT INFORMATION (Must be filled out completely)

Name (last, first) _____ Gender: Male Female

Date of Birth: _____

Telephone: _____ OK to leave message: Yes No

Address/Street, City, State, Zip Code _____

Country of Origin: _____

First Language: _____ Other Languages Spoken: _____

Fluent in English: Yes No Interpreter: Required Preferred

Marital Status: Single Married Widowed Divorced



Legal Status: Asylum Seeker Asylee Refugee Temporary Protective Status
Withholding Removal Undocumented Student Visa Citizen

Work Authorization: Yes No **Currently Working:** Yes No

Health Insurance: Yes No If Yes, what type: _____

Has client been to BMC previously? Yes No

Referred by: _____ **Agency** _____

Phone: _____ **Email:** _____

Relationship to Client: _____

ASYLUM SEEKER CLIENT INFORMATION

Date of most recent arrival in US: _____ **Past 1 yr filling:** Yes No

Torture survivor: Yes No **Family of torture survivor:** Yes No

Does your client have physical scars resulting from torture? Yes No

Known details of persecution or torture:

BASIS FOR ASYLUM APPLICATION

Check all that apply:

Race Religion Nationality Political opinion

Membership in a particular social or ethnic group

Client has Attorney: Yes No

FORENSIC EVALUATION INFORMATION *Please allow a minimum of 3 months advance notice*

What type of evaluation are you requesting? Physical Psychological Gynecological



Is this an: Asylum Interview Affirmative Merits Hearing Defensive Hearing

Date of Interview or Hearing: _____

Date affidavits need to be submitted: *Please be specific:* _____

ATTORNEY INFORMATION

Is this case: PAIR Other Pro bono Reduced Fee Regular Fee

Name: _____

Agency/Firm: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Fax: _____

Email: _____

