



SPIRASI: INITIAL ASSESSMENT REFERRAL FOR SURVIVORS OF TORTURE

Referral form for **Initial Assessment** which includes medical, psychotherapeutic and psychosocial assessment.

SPIRASI ID NUMBER

To be completed by a Health Professional to request an Initial Assessment only.
Please ensure form is completed clearly, giving as much information as possible.

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

First Name:		Family Name:		
Current Address:		Person Identity No:		
		Application Reference No:		
		Telephone No:		
		Gender:	MALE	FEMALE
		Date of Birth:		
Marital Status:		Separated Child (unaccompanied)	YES NO	
Number of Dependents in Ireland:		Number of Dependents in Country of Origin:		
Medical Card No:		Country of Origin:		
Ethnic Group:		Native Language(s):		
Interpreter Required:	YES NO	If YES, which language:		

2. Residency Status: (Please tick the relevant box.)

Asylum Seeker Refugee Other
If 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 If Yes: Year/Month: _____

Where? Country _____ Facility: _____

Why? _____ By whom? _____

If more than once how many times detained? _____ For how long in total? _____

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? _____

4. Current situation:

Please give a brief description of...

a. Current physical and psychological 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		e-mail	
Address		Telephone	
		Fax	

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

Please return or contact for enquiries:

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