



Centre for the Care of Survivors of Torture (CCST) MEDICAL REFERRAL FORM

CCST ID NUMBER	
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To Be Completed By A General Practitioner (GP) To Request A Medical Assessment Only.
Please ensure form is completed clearly, giving as much information as possible.

1. Personal Details of Client:

Name:	TRC No:		
Current Address:	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 CCST may be able to assist your client?

6. Name Of Referrer: _____

7. Please tick relevant box: **GP** **AMO**

Your Contact Details:

Name		e-mail	
Address		Telephone	
		Fax	

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

Please return or contact for enquiries:

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