

Survivors of Torture Collaborative

A partnership between Nationalities Service Center, HIAS Pennsylvania, and Lutheran Children and Family Service Pennsylvania

Screening and Referral Form

DATE: _____

REFERRING AGENCY:

Referred by: _____ Agency: _____

Phone: (____) _____ Fax: (____) _____ E-mail: _____

City: _____ State: _____ Zip: _____

PERSON BEING REFERRED:

Last Name _____ First _____ Middle _____

Primary Phone _____ Secondary Phone/e-mail _____

Address _____ City _____ State _____ Zip _____

Gender _____ DOB _____ Age at intake _____

Country of Origin _____ Ethnicity _____

Does this client speak English? Yes Some None Language(s): _____

Is the client aware of this referral? Yes No

IN ADDITION TO CASE MANAGEMENT, THIS CLIENT MAY NEED:

During the intake process please ask your client the following questions. If he/she answers "yes" to any of the questions below, please refer them to Kerenza Reid (215.893.8400 x1542), for the Survivors of Torture Collaborative.

- Yes No
- 1.) In his/her home country, was he/she or a family member ever *threatened* by members of the government, military/militia, rebel group, police or political group?
- Yes No
- 2.) Was he/she or a family member ever *hurt physically or emotionally* by members of the government, military/militia, rebel groups, police or political groups?
- Yes No
- 3.) Was he/she ever *hurt or threatened* while detained, arrested, or jailed? This includes *threats to harm* friends or family members.

Notes regarding client's experience of any of the above: