

Albion Mediation Solicitor's Client Referral Form



Referral to Mediation

Please email to: mediation@1str.co.uk

Referred under:

Section 29 (funding code/CLS APP7 & FM1 required if unsuitable/unsuccessful)

Pre – Application Protocol (Private Client/FM1 required in unsuitable/unsuccessful)

Your Client

Title _____
Name _____
Address _____

Post Code _____
Telephone _____
Mobile No. _____
Email _____
D.o.B. _____

Other Party

Title _____
Name _____
Address _____

Post Code _____
Telephone _____
Mobile No. _____
Email _____
D.o.B. _____

Case Details: i.e. Financial, Children, all Issues,

If either party has any disability requirement please let us know. Not all offices have wheelchair access.

All our documents and letters are available in large print.

Would the client benefit from receiving information in another language?

Interpreter required?

Would the client benefit from receiving information in another language?

Interpreter required?

| | |
|---|--|
| Referrer's Solicitor Name: Firm: DX: Telephone No: | Other Party's Solicitor Name: Firm: DX: Telephone No: |
|---|--|

| | |
|---|---|
| Is Other Party Aware of Referral? No/Yes | Is Other Party Aware of Referral? No/Yes |
| Has CAFCASS or any other relevant agency been involved either now or previously No/Yes | |
| Recent or Current Court Proceedings, please give details of court and next hearings: | |

| |
|--|
| <h2 style="margin: 0;">Child Referral Form</h2> <p style="margin: 0;">Please attach this as an addition to our main referral form</p> |
|--|

All information will be treated in the strictest confidence

| | |
|-----------|---------------|
| Referrers | Name: |
| | Address: |
| | Telephone No: |

| | |
|---|-----------------------------|
| Adult with whom child(ren) reside <i>(Address if different)</i> | Name: |
| | Relationship to Child(ren): |
| | Address: |
| | |
| | Telephone No: |

| Name(s) of Child(ren): | Date of birth | Boy/Girl |
|------------------------|---------------|----------|
| | | |
| | | |
| | | |
| | | |

| | |
|--|--------|
| Who has parental responsibility? ** | |
| Is the Child(ren) aware of the referral? | Yes/No |
| Is the other parent aware of the referral? | Yes/No |

| |
|---|
| Is there a CAFCASS officer involved currently? Yes/No |
| Name: |
| Address: |
| |
| Telephone No: |

| |
|--|
| Additional background information relevant to the contact arrangements i.e. medical conditions and/or disability: |
| a. Child(ren): |
| b. Parents: |

** Nb. Child Consultation cannot take place without the permission of all adults with parental responsibility.

once completed the form is emailed to mediation@1str.co.uk