

LAA Solicitor Referral Form

PLEASE COMPLETE IN BLOCK CAPITALS

It is important that you give us full details of the Partner so that we may make contact with them.

Applicant		Other party	
Name:	<input type="text"/>	Name:	<input type="text"/>
Address:	<input type="text"/>	Address:	<input type="text"/>
	<input type="text"/>		<input type="text"/>
	Postcode		Postcode
Home Tel:	<input type="text"/>	Home Tel:	<input type="text"/>
Work Tel:	<input type="text"/>	Work Tel:	<input type="text"/>
Mobile:	<input type="text"/>	Mobile:	<input type="text"/>
Email:	<input type="text"/>	Email:	<input type="text"/>
Date of Birth:	<input type="text"/>	Date of Birth:	<input type="text"/>
Occupation:	<input type="text"/>	Occupation:	<input type="text"/>
NI Number:	<input type="text"/>	NI Number:	<input type="text"/>
Disability	Yes <input type="checkbox"/> No <input type="checkbox"/>	Disability	Yes <input type="checkbox"/> No <input type="checkbox"/>

Areas of Mediation			
Children issues	<input type="checkbox"/>	Property & Finance	<input type="checkbox"/>
Both Children & Property	<input type="checkbox"/>	Other	<input type="checkbox"/>

Applicant Lawyer		Other party Lawyer	
Name:	<input type="text"/>	Name:	<input type="text"/>
Firm:	<input type="text"/>	Firm:	<input type="text"/>
Address:	<input type="text"/>	Address:	<input type="text"/>
	<input type="text"/>		<input type="text"/>
	Postcode		Postcode
Telephone:	<input type="text"/>	Telephone:	<input type="text"/>
Fax:	<input type="text"/>	Fax:	<input type="text"/>
Email:	<input type="text"/>	Email:	<input type="text"/>
DX:	<input type="text"/>	DX:	<input type="text"/>



Children Details

Forename: <input style="width: 90%;" type="text"/> Surname: <input style="width: 90%;" type="text"/> Living with: <input style="width: 90%;" type="text"/> Date of Birth: <input style="width: 90%;" type="text"/> Are there any significant health issues? Yes <input type="checkbox"/> No <input type="checkbox"/> Are there any significant education issues? Yes <input type="checkbox"/> No <input type="checkbox"/>	Forename: <input style="width: 90%;" type="text"/> Surname: <input style="width: 90%;" type="text"/> Living with: <input style="width: 90%;" type="text"/> Date of Birth: <input style="width: 90%;" type="text"/> Are there any significant health issues? Yes <input type="checkbox"/> No <input type="checkbox"/> Are there any significant education issues? Yes <input type="checkbox"/> No <input type="checkbox"/>
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Referral

Is there a history of domestic abuse or intimidation? Yes <input type="checkbox"/> No <input type="checkbox"/> Is the other party aware of the referral? Yes <input type="checkbox"/> No <input type="checkbox"/> Is the other party willing to attend? Yes <input type="checkbox"/> No <input type="checkbox"/> Are Social Services involved? Yes <input type="checkbox"/> No <input type="checkbox"/>	Are there any court orders in force? e.g. injunctions: Yes <input type="checkbox"/> No <input type="checkbox"/> Can we have the Client's permission to contact the other party? Yes <input type="checkbox"/> No <input type="checkbox"/> Are there Child Protection issues? Yes <input type="checkbox"/> No <input type="checkbox"/> Are Cafcass involved? Yes <input type="checkbox"/> No <input type="checkbox"/>
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Preferred Appointment Venue

Please indicate the following by numbering them 1-7, with 1 being your preferred venue.

<input type="checkbox"/> Dorking	<input type="checkbox"/> Epsom	<input type="checkbox"/> Guildford	<input type="checkbox"/> Reigate
<input type="checkbox"/> Egham	<input type="checkbox"/> Woking	<input type="checkbox"/> Esher	



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