**SAR 5**

# Referral Recommendation and Decision Record

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| **Name of adult(s):** |  |
| **D.O.B.:** |  |
| **D.O.D (if applicable):** |  |
| **Referral received from:** |  |
| **Date referral received:** |  |

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| Reason for Referral |
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| Agencies providinginformation: | Issues identified and view on whether a SAR is required: |
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| Date referral considered by Case Review Subgroup: |  |
| Recommendation on whether a SAR is required and basis for decision making |
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| If a SAR is recommended:* Recommendation on methodology
* Recommendation on key themes
* Recommendation on composition of panel
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| Subgroup Chair or representative(Date and Signature) |  |

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| Decision on Behalf of WSAB |
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| WSAB Chair or representative(Date and Signature) |  |