**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 providing  information: | 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 | |
|  | |
| Subgroup Chair or representative  (Date and Signature) |  |

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