**Family & Domestic Violence Support Services Referral Form**

**If immediate support or accommodation is required, please call Crisis Care on 92231111 or Police on 000 or 131444.**

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| **Client Details** |
| First Name:  | Family Name:  |
| Address:  |  Postcode: |
| Gender: Female [ ]  Non-binary [ ]  Prefer not to disclose [ ]  |
| Date of Birth:  | Aboriginal and/or TSI? Yes [ ]  No [ ]  |
| Phone No:  |  Email: |
| Is it safe to call: Yes [ ]  - If yes, best time to Contact: No [ ]  - If no, please elaborate: |
| Emergency Contact Name: | Emergency Contact Ph: |
| Country of Birth: | Arrival date in Australia:Visa Type or number:  |
| Languages Spoken: | Needs Interpreter? Yes [ ]  No [ ]   |
| Marital Status: Single [ ]  Married [ ]  Divorced [ ]  De-facto [ ]  Separated [ ]  Widow [ ]  |
| Living With partner: Yes [ ]  No [ ]   | Names and dates of birth of Children (if any):  |
| Source of Income: | Occupation: |
|  |  |
| **Safety** |
| Is there a Violence Restraining order in place? | Final[ ]  Interim [ ]  No VRO [ ]   |
| Has a Critical Risk Assessment & Risk Management Framework (CRAMF) been completed within the last 3 months? | Yes [ ]  Please send with referral. No [ ]   |
| Is the client worried about their safety? | Not afraid [ ]  Afraid [ ]   | Terrified [ ]  Unable to answer [ ]   |
| **Supports required** |
| Please tick practical supports the client requires to discuss in the initial appointment. |
| Counselling [ ]  Safety planning [ ]  GP appointment [ ]   | Financial aid\* [ ]  Legal advice\* [ ]  Immigration\* [ ]   | Case work [ ]  Support group [ ]  Other [ ]   |
| \*Referrals and follow up only. Ishar does not provide these services directly. |

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| **Referee Details** |
| Name: | Referrer Role: |
| Email: | Phone: |
| Organisation: | Date of referral:  |
| Would you like a warm referral for this client? [ ]  If yes, Ishar will contact referrer to organise a suitable time for a warm handover  |

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| **Reason for referral** |
| If there is a recent police incident, please provide details: |
|  |

**Client Consent**: Please confirm if the client has consented to be contacted by Ishar.

I give my consent to this referral [ ]

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Verbal Consent**: Yes [ ]  No [ ]

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**All referrals to be sent to :** referrals@ishar.org.au