**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