DVassist

CLIENT REFERRAL FORM

We will only contact the client directly if you have obtained and documented their consent for us to do so.
If there are specific days or times that are safer for us to contact the client, please include those details below. While we will do our best to call at the preferred time, we cannot guarantee this. Please inform the client that they are welcome to contact us directly at any time.

REFERRING AGENCY DETAILS

REFERRING SERVICE:

REFERRING STAFF MEMBER: DATE:

EMAIL: PHONE NUMBER:

PROGRAM OPTIONS

☐ MULTI-SESSION TRAUMA-INFORMED COUNSELLING

☐ SHORT-TERM CASE MANAGEMENT AND SAFETY PLANNING

WILL THE CLIENT CONTINUE TO BE INVOLVED WITH YOUR SERVICE/PROGRAM? ◉ YES ○ NO

CLIENT INFORMATION

FIRST NAME: SURNAME:

PREFERRED NAME: DATE OF BIRTH:

PHONE NUMBER: GENDER:

SAFE TO PHONE: ○ YES ○ NO
SAFE TO LEAVE A MESSAGE: ○ YES ○ NO

PRONOUNS:

Please advise if we can leave a voice message for the client and that we will be calling from a private number.

DETAILS OF TIMES AND DAYS AVAILABLE TO SAFELY CONTACT THE CLIENT:

ADDRESS:

REGION OF WESTERN AUSTRALIA:

CLIENTS CULTURAL IDENTITY

○ ABORIGINAL ○ TORRES STRAIT ISLANDER ○ OTHER

COUNTRY OF BIRTH: INTERPRETER REQUIRED: ○ YES ○ NO

LANGUAGE:

DVassist

Please note, the information provided below is only used to develop a tailored therapeutic plan with the client based on their current needs and existing (if any supports.

MENTAL HEALTH DIAGNOSIS (IF ANY):

DISABILITIES:

OTHER SUPPORTS IN PLACE:

CLIENT'S EXPERIENCE OF FAMILY AND DOMESTIC VIOLENCE

- ☐ PHYSICAL ABUSE
- ☐ PSYCHOLOGICAL/EMOTIONAL ABUSE
- ☐ TECH-FACILITATED ABUSE
- ☐ VERBAL ABUSE
- ☐ CULTURAL & SPIRITUAL ABUSE
- ☐ POST SEPARATION ABUSE
- ☐ SEXUAL ABUSE
- ☐ FINANCIAL ABUSE
- ☐ COERCIVE CONTROL
- ☐ ISOLATION
- ☐ SYSTEMIC ABUSE
- ☐ SOCIAL ABUSE
- ☐ OTHER _____

BRIEF SUMMARY OF FAMILY AND DOMESTIC VIOLENCE HISTORY

IMMEDIATE CONCERNS AND RISK FACTORS

PROFESSIONAL JUDGEMENT OF CLIENTS LEVEL OF RISK:

- ◯ NOT AT RISK
- ◯ LOW RISK
- ◯ MEDIUM RISK
- ◯ HIGH RISK

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CHILDREN'S INFORMATION

NAME:	DOB:

PERSON USING VIOLENCE (PUV)

KNOWN AS:	DOB:	GENDER:

ANY ADDITIONAL INFORMATION

CONSENT

CONSENT FROM THE PERSON BEING REFERRED IS REQUIRED TO MAKE THIS REFERRAL

- ☐ I UNDERSTAND AND GIVE CONSENT TO THIS REFERRAL
- ☐ I GIVE PERMISSION FOR DVASSIST TO OBTAIN AND RELEASE INFORMATION TO THE PERSON/AGENCY REFERRING
- ☐ I GIVE PERMISSION TO DVASSIST TO STORE INFORMATION OBTAINED DURING THE REFERRAL PROCESS

NAME: _____ DATE: _____

SIGNED: _____

OR VERBAL CONSENT GIVEN TO THE ABOVE ◯ YES ◯ NO

NAME: _____ DATE: _____

SIGNED: _____

PLEASE SEND REFERRALS TO:
CLIENTSERVICES@DVASSIST.ORG.AU