

Integrated Family Violence Services/ Circle of HeArts Referral Form

Authority to Release/Exchange Information

I _____ /_____/_____
(Name) (d.o.b.)

give permission for to contact the person/agency/s listed:

- _____
- _____
- _____
- _____
- _____

to exchange information about myself (and my children if relevant). This information is to be used for the purpose of providing appropriate services in line with mutually agreed goals or case plans.

I am aware that this Consent Form is valid until I withdraw my consent or until the expiry date noted below.

Signed: _____ Date: _____

Name (please print): _____

Expiry Date: _____ (no more than three months from date of signing)

VERBAL CONSENT FOR THE RELEASE OF INFORMATION

(**ONLY** to be used when the client is not present to provide written consent)

Verbal consent obtained: Yes No

Worker's Name: _____ Signature: _____

Expiry Date: _____ (no more than three months from date of providing verbal consent)

It is the policy of Integrated Family Violence Services to obtain consent in writing. Where consent is verbal, Integrated Family Violence Services will endeavour to obtain written consent at a later date.

Integrated Family Violence Services/ Circle of HeArts Referral Form

Date: Time: Referring Agency:
 Worker: Referrer's Name:
 Referrer's Contact:

CONSENT

Has the client consented to the referral being made? YES •• NO
 Is the Authority to release information between referring agencies attached? YES •• NO

IMMEDIATE RISK/SAFETY (Please complete attached Risk Assessment Form)

Is it safe to talk now? YES •• NO If **NO**, when would it be safe to talk?.....
 Where is the perpetrator?.....
Risk category: Requires immediate protection/High •• Elevated risk/Medium At risk/low

CLIENT DETAILS

Name & Contact	Cultural	Housing & Income
First name:	Country of birth:	Current accommodation type:
Family name:	Cultural background:	<input type="checkbox"/> Private Rental <input type="checkbox"/> OoH
D.O.B.	Interpreter required? <input type="checkbox"/> YES •• <input type="checkbox"/> NO	<input type="checkbox"/> THM <input type="checkbox"/> E/A
Address:	Preferred language:	Usual accommodation:
..... Postcode:	Aboriginal and/or Torres Strait Islander?	<input type="checkbox"/> Private Rental <input type="checkbox"/> OoH
Mobile Phone:	<input type="checkbox"/> Aboriginal <input type="checkbox"/> TSI	<input type="checkbox"/> THM <input type="checkbox"/> None
Other:	<input type="checkbox"/> Both <input type="checkbox"/> Neither	Residing with perpetrator? <input type="checkbox"/> YES •• <input type="checkbox"/> NO
What time is it safe to call?		Is it safe to remain? <input type="checkbox"/> YES •• <input type="checkbox"/> NO
Safe to leave a message? <input type="checkbox"/> YES •• <input type="checkbox"/> NO		Employment status:
		Primary income:

Reason for contact:

MOST RECENT INCIDENT OF VIOLENCE

When was the most recent incident of violence and what occurred? Did the Police attend? YES •• NO

MOTHER/CARER'S RELATIONSHIP TO PERPETRATOR

Married Divorced Defacto Ex-partner Carer
 Girlfriend Same-sex partner Parent Grandparent Sibling

Integrated Family Violence Services/ Circle of HeArts Referral Form

Other

FAMILY MEMBER (mother, siblings etc.)

Name	Gender	D.O.B.	With client?	Child Protection?	Family Court?
		/ /	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
		/ /	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
		/ /	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
		/ /	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
		/ /	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

If children are not with the client where are they?

Does the perpetrator have access with the children? YES NO

Are there concerns about the children's safety? YES NO If **YES** has a Child Protection Report been made? YES NO

Additional information regarding children:

LEGAL

Is there an Intervention Order in place? YES NO

If **YES**, what is the date of Order?/...../..... Is the perpetrator excluded from the residential home? YES NO

If **NO**, does the client want to pursue an Intervention Order? YES NO

Additional legal concerns:

OTHER SERVICES INVOLVED

Service/Agency	Contact Person	Contact Details
Eg: Family Violence Counselling		

Family Violence related support needs: (i.e. Advocacy / Legal / Relocation / Referral to counselling / Further safety planning)

How is the client going to stay safe?



Aide memoire

Note: these risk and vulnerability factors should be explored through the course of a conversation. Risk indicators are not intended to be asked as part of a data collection process and should not be used as such.

Risk or vulnerability factor	Presence of factor	
	Yes	No
Victim		
Pregnancy/new birth*	<input type="checkbox"/>	<input type="checkbox"/>
Depression/ mental health issue	<input type="checkbox"/>	<input type="checkbox"/>
Drug and/or alcohol misuse/abuse	<input type="checkbox"/>	<input type="checkbox"/>
Has ever verbalised or had suicidal ideas or tried to commit suicide	<input type="checkbox"/>	<input type="checkbox"/>
Isolation	<input type="checkbox"/>	<input type="checkbox"/>
Perpetrator		
Use of weapon in most recent event*	<input type="checkbox"/>	<input type="checkbox"/>
Access to weapons*	<input type="checkbox"/>	<input type="checkbox"/>
Has ever harmed or threatened to harm victim	<input type="checkbox"/>	<input type="checkbox"/>
Has ever tried to choke the victim*	<input type="checkbox"/>	<input type="checkbox"/>
Has ever threatened to kill victim*	<input type="checkbox"/>	<input type="checkbox"/>
Has ever harmed or threatened to harm or kill children*	<input type="checkbox"/>	<input type="checkbox"/>
Has ever harmed or threatened to harm or kill other family members	<input type="checkbox"/>	<input type="checkbox"/>
Has ever harmed or threatened to harm or kill pets or other animals*	<input type="checkbox"/>	<input type="checkbox"/>
Has ever threatened or tried to commit suicide*	<input type="checkbox"/>	<input type="checkbox"/>
Stalking of victim*	<input type="checkbox"/>	<input type="checkbox"/>
Sexual assault of victim*	<input type="checkbox"/>	<input type="checkbox"/>
Previous or current breach of intervention order	<input type="checkbox"/>	<input type="checkbox"/>
Drug and/or alcohol misuse/abuse*	<input type="checkbox"/>	<input type="checkbox"/>
Obsession/jealous behaviour toward victim*	<input type="checkbox"/>	<input type="checkbox"/>
Controlling behaviour*	<input type="checkbox"/>	<input type="checkbox"/>
Unemployed*	<input type="checkbox"/>	<input type="checkbox"/>
Depression/mental health issue#	<input type="checkbox"/>	<input type="checkbox"/>
History of violent behaviour (not family violence)	<input type="checkbox"/>	<input type="checkbox"/>
Relationship		
Recent separation*	<input type="checkbox"/>	<input type="checkbox"/>
Escalation – increase in severity and/or frequency of violence*	<input type="checkbox"/>	<input type="checkbox"/>
Financial difficulties	<input type="checkbox"/>	<input type="checkbox"/>

* May indicate an increased risk of the victim being killed or almost killed. # Mental health issues such as depression and paranoid psychosis, which focuses on the victim as hostile, are high risk when they are present in conjunction with other risk factors, particularly a previous history of violence. The presence of a mental health issue must be carefully considered in relation to the co-occurrence of other risk factors.



Circle of HeArts – Referral Form

Date of Referral: _____

Name of Client: _____

Reason for referral to Circle of HeArts: *(e.g., previous and/or current family violence)*

Has the client been in a group in the past? How did they manage in the group setting?

How do you see this group supporting your client?

Is there anything that you are aware of that may prevent your client from attending the group regularly?

Referring person: _____

Organisation: _____

Contact details: _____