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| **Your Choice Project Referral form** | **A circle with text and words  Description automatically generated** | Logo, company name  Description automatically generated |

**Please fully complete this referral form.**

**Failure to do so will result in a delay in the referral being processed.**

**Thank you.**

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| **Referrer details** |
| Name:  |  | Date of Referral: |  |
| Email address:  |  | Phone number: |  |
| Please confirm that consent has been gained for this referral:  |   Yes [ ]  No [ ] **Please note, we cannot accept referrals without the Client’s consent** |

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| **Details of person being referred** |
| Name:(preferred pronouns) |  | D.O.B: |  |
| Email: |  | Phone: |  |
| Support required for engagement (Interpreter, language, literacy, etc):  |  | Address: |  |
| Gender:  |  | Sexuality: |  |
| Ethnicity: |  | Religion: |  |
| Status of any child or adult safeguarding measures: |  |
| Has there recently been or is there going to be a separation from partner?  |  | Are there ongoing care proceedings? If so please give details  |  |
| Details of current criminal/family court proceedings or injunctions concerning domestic violence and abuse: |   | Details of previous criminal convictions, injunctions, cautions or arrests for domestic violence and abuse: |  |
| Current relationship status: |  |
| Has a DASH RIC been completed within the last 12 months? | If so, please confirm score/risk level: |
| Type of abuse (Please put an X next to the type/s of abuse used) | Physical Sexual Coercive control Economic/financial EmotionalViolent or threatening behaviour Harassment and Stalking  |
| Mental health concerns:  | (If yes, please describe)  |
| Substance misuse concerns:  |  (If yes, please describe)  |
| Has Client engaged in any Domestic Abuse work previously?  |  (If yes, please describe and provide dates)  |
| Is Client currently engaging in any other behaviour change work or treatment such as counselling, substance misuse treatment, psychiatric treatment, etc? |  (If yes, please describe)  |
| Are there any risks to professionals posed by the Client that you are aware of? |  (If yes please describe)  |

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| **Children’s details****(all children connected to perpetrator - including stepchildren, foster children, and any other children in the home or under their care)** |
| First name  | Surname | Date of birth | Sex | Living and contact arrangements  |
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| Is there, or has there been, disagreement about child contact arrangements: Yes [ ]  No [ ] Is there an intention to issue Children Act proceedings or are there Children Act proceedings before the Family Court currently? Yes [ ]  No [ ] Please confirm status of any court proceedings:What are the current child contact arrangements? |
| Is Children’s Social Care involved with the family? | Yes [ ]  No [ ]  |
| Name of Social Worker |  |
| Contact details of social worker |  |
| Details of involvement |  |

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| **Other agencies** |
| Is Adult Social Care involved with anyone in the family? | Yes [ ]  No [ ]  |
| Name of Social Worker |  |
| Contact details of social worker |  |
| Details of involvement |  |
| Are any other agencies involved with this referral? | Yes [ ]  No [ ]  |

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| Agency 1  |  |
| Name of worker |  |
| Contact details |  |
| Detail of involvement |  |
|  |
| Agency 2 |  |
| Name of worker |  |
| Contact details |  |
| Detail of involvement |  |

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| **Referral details** |
| What has led to this referral? Please provide details of the following:* All known incidents of DVA
* Details of risk factors
* Current DVA
* Historical DVA
* Family dynamics
* Motivation to change and address behaviour
* Any safety plans currently in place for client, partners, ex partners, family members or children
* Partner’s, ex-partner’s, family member’s preference of support (eg- emotional support, check in, updates)
* Any other relevant history
* Concerns about health and well-being of Client and/or survivors
* Protective factors

Please give as much information as possible |
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| **If you have confidential contact details for a partner, ex-partner or family member connected to the Client you are referring to the Your Choice Project, please complete this section of the form separately and ensure the details are not shared with the Client.****Please provide details with all partners/ex partners that the Client has children with.** |

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| **Survivor connected to person being referred.****The YCP requires details of any partners, ex partners or family members that have experienced domestic violence and abuse with the person being referred, as known:** |
| Name: |  | D.O.B: |  |
| Relationship to Client referred to YCP: |  |
| Email:  |  | Phone: |  |
| Gender:  |  | Sexuality: |  |
| Ethnicity: |  | Religion: |  |
| Address: |  | Support required for engagement (Interpreter, language, literacy, etc.) |  |
| Mental health concerns:  |  (If yes, please describe)  |
| Substance misuse concerns:  |  (If yes, please describe)  |
| Are there any risks to professionals posed by survivor that you are aware of |  (If yes please describe)  |
| Is this person aware of the referral? Yes [ ]  No [ ] Is it safe to make contact with this survivor? Yes [ ]  No [ ] Preferred/safe way to contact survivor:  |

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| **Any other survivor connected to person being referred.** |
| Name: |  | D.O.B: |  |
| Relationship to Client referred to YCP: |  |
| Email:  |  | Phone: |  |
| Gender:  |  | Sexuality: |  |
| Ethnicity: |  | Religion: |  |
| Address: |  | Support required for engagement (Interpreter, language, literacy, etc.) |  |
| Mental health concerns:  |  (If yes, please describe)  |
| Substance misuse concerns:  |  (If yes, please describe)  |
| Are there any risks to professionals posed by survivor that you are aware of |  (If yes please describe)  |
| Is this person aware of the referral? Yes [ ]  No [ ] Is it safe to make contact with this survivor? Yes [ ]  No [ ] Preferred/safe way to contact survivor:  |

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| **Any other survivor connected to person being referred.** |
| Name: |  | D.O.B: |  |
| Relationship to Client referred to YCP: |  |
| Email:  |  | Phone: |  |
| Gender:  |  | Sexuality: |  |
| Ethnicity: |  | Religion: |  |
| Address: |  | Support required for engagement (Interpreter, language, literacy, etc.) |  |
| Mental health concerns:  |  (If yes, please describe)  |
| Substance misuse concerns:  |  (If yes, please describe)  |
| Are there any risks to professionals posed by survivor that you are aware of |  (If yes please describe)  |
| Is this person aware of the referral? Yes [ ]  No [ ] Is it safe to make contact with this survivor? Yes [ ]  No [ ] Preferred/safe way to contact survivor:  |

**Please return referral form to:**

**Secure email:** **Info@yourchoiceproject.cjsm.net** **(do not use this email address unless you are sending from a cjsm email addres)**

**Unsecure email:** **contact@yourchoiceproject.org.uk** **(password protected)**

**We will acknowledge receipt of your referral.**

**If you do not hear from the YCP, please contact us on 0115 6950734**