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| **Domestic Abuse Outreach Service**  **Referral Form** | G:\LEVEL3\Business Support\Marketing\NEW LOGOS 2017\FINAL ACT LOGOS\ACT_Logo_CMYK.jpg |

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| **Risk Assessment**  *(Please note that this service is commissioned to assist victims of abuse deemed to be at MEDIUM risk only. This equates to a DASH score between 8 and 14) If required, the DASH tool can be downloaded at* [*https://www.dashriskchecklist.co.uk*](https://www.dashriskchecklist.co.uk) | | | |
| Dash Score |  | Date of Assessment |  |
| *Please enclose/attach a copy of DASH with referral, as this will help us to provide an informed and seamless service for the victim. Should a copy not be available, please clarify circumstances/reason.* | | | |

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| **Supporting Information** | | | | | |
| **Contact Details** | | | | | |
| Referral Agency |  | | | | |
| Name of Referrer |  | | | | |
| Contact Number |  | | Mobile | |  |
| Email Address |  | | | | |
| Has consent been received for this referral? | | | Yes | | No |
| If consent has not been received, what will be the victim’s understanding when ACT makes contact? (*Please state)* | | | | | |
| Has a referral also been made to MARAC? | | | Yes | | No |
| If yes, what was the date of the referral? | | |  | | |
| Any relevant or current Court Orders? | | | Yes | | No |
| If yes, please specify: | | | | | |
| **Nature of Abuse** *(Please select)* | | | | | |
| Coercive Control | | Financial | | Harassment/Stalking | |
| Honour Based/FGM | | Online/Digital | | Physical | |
| Psychological/Emotional | | Sexual | | Other | |
| When was the approximate date of the most recent incident of abuse? | | | | | |
| **Other Agency Involvement** | | | | | |
| Please specify all other agencies known to be currently working with the victim and their family | | | | | |

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| **Victim Details** | | | | | | | |
| Name *(Also known as)* | |  | | | | | |
| Address *(Including postcode)* | |  | | | | | |
| **Safe** Contact Number | |  | | | | | |
| **Safe** Email Address | |  | | | | | |
| Preferred contact times | |  | | | | | |
| Preferred means of contact | |  | | | | | |
| Gender | Male | | | Female | | | Other *(Please Specify)* |
| Date of Birth |  | | | Ethnicity | | |  |
| Immigration Status |  | | | | | | |
| Religion/Faith/Belief |  | | | | | | |
| First Language |  | | | | | | |
| Is an interpreter required? | Yes | | | | No | | |
| Disability | Yes | | | | No | | |
| *If yes, please specify* | | | | | | | |
| Risk Factors | *(e.g. Pregnancy, self harm, mental health, drugs and alcohol)* | | | | | | |
| Is a joint visit needed? | Yes | | | | No | | |
| If yes, please state reason why a joint visit is needed | | | | | | | |
| Home Owner | | | Tenant | | | Other (Please specify) | |
| Landlord details *(if applicable)* | | | | | | | |

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| **Perpetrator Details** | | | | | |
| Name/Alias |  | | | | |
| Address *(Including Postcode)* |  | | | | |
| Date of Birth |  | | Immigration Status |  | |
| Relationship to victim |  | | Are they still in a relationship with the victim? | Yes | No |
| Are they living together? | Yes | No | If living apart, is the perpetrator likely to visit? | Yes | No |
| Additional Risk Factors | *(e.g. Alcohol and drug use, mental health, pets, weapons)* | | | | |

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| **Details of Children** | | | | | | |
| Name of child (1) |  | | | | | |
| Date of Birth |  | Gender | | |  | |
| Address |  | | | | | |
| Name of School |  | | | | | |
| Involvement with CYP *(CP / CIN / CAF)* | Yes | | | No | | |
| If yes, name and contact details of lead professional: | | | | | | |
| Name of Child (2) |  | | | | | |
| Date of Birth |  | | Gender | | |  |
| Address |  | | | | | |
| Name of School |  | | | | | |
| Involvement with CYP *(CP / CIN / CAF)* | Yes | | | No | | |
| If yes, name and contact details of lead professional: | | | | | | |
| Name of Child (3) |  | | | | | |
| Date of Birth |  | | Gender | | |  |
| Address |  | | | | | |
| Name of School |  | | | | | |
| Involvement with CYP *(CP / CIN / CAF)* | Yes | | | No | | |
| If yes, name and contact details of lead professional: | | | | | | |
| Name of Child (4) |  | | | | | |
| Date of Birth |  | | Gender | | |  |
| Address |  | | | | | |
| Name of School |  | | | | | |
| Involvement with CYP *(CP / CIN / CAF)* | Yes | | | No | | |
| If yes, name and contact details of lead professional: | | | | | | |

Signature of Referrer: ………………………………………………… Date: ……………………………………….

Signature of Service User ………………………………………….... Date …………………………………........

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| We will treat your information as confidential and we will not share it with any other organisation unless we are required by law to share it or unless you or any other person will come to some harm if we do not share it. In any case we will only ever share the minimum information we need to share.  I am aware that I can withdraw or change my consent at any time by contacting the Business Support Team on the details below. |

**Completed referrals should be signed and sent to:**

Anglia Care Trust, Unit 8, The Square, Martlesham Heath, Ipswich, Suffolk IP5 3SL

Tel: 01473 622888 Fax: 01473 618660 Email: [admin@angliacaretrust.org.uk](mailto:admin@angliacaretrust.org.uk)