REFERRAL

This e-form contains fillable PDF fields that can be completed electronically (or by hand), saved and then emailed to Referral@beyonddv.org.au

Date of Referral: ____/____/____

PERSON BEING REFERRED DETAILS

Name:

Age: DOB: Gender:

Phone: Email:

Address:

Do you identify as:

Aboriginal Torres Strait Islander Both Australian South Sea Islander CALD Disability None

Country of birth: Language at home:

Is an interpreter required: Yes No

Please tick if it is safe to: Call Text Voicemail Email

Details of why the referral is being made:

Is the person pregnant? Yes No

Is the person engaged in a new relationship? Yes No

If YES, how long have they been in the new relationship?

Emergency Contact:

Name: Relationship:

Email: Phone:

PERSON USING VIOLENCE DETAILS (PUV)

Is there a Domestic Violence Order (DVO) in place? Yes No Temporary awaiting court

Police Private Date of Order:

Any safety concerns:

REFERRING AGENCY DETAILS

Name of Referring Agency:

Name of Referring Worker:

Phone: Email:

Current support being offered by agency or other government/ non-government agencies:

Agency	Type (E.g., case worker)

Please tick what supports are being offered by the organisations?

Housing ☐ Case Management ☐ Counselling ☐ Financial Support ☐ Other ☐

Give Details:

Have you assisted with creating a Safety Plan with client? Please attach.

CHILDREN AND DEPENDENTS

Childs Name	**Date of Birth**	**Gender**	**Relationship to Primary Carer**	**Relationship to PUV**	**Named on DVO**
					Yes ☐ No ☐
					Yes ☐ No ☐
					Yes ☐ No ☐
					Yes ☐ No ☐

Care arrangements:

Is Child Safety involved? Yes ☐ No ☐

Details of Child Safety Intervention / Involvement

Are there any Family Law Court order in place? Yes ☐ No ☐ Pending ☐

Details of Family Law Court matter

I agree to the following:

☐ Must reside in the **Brisbane area** or be willing to travel from within the Greater Brisbane Area

☐ Must be out of the abusive relationship for a minimum of **three months**.

☐ Understand that Beyond DV is **not a crisis service**.

☐ Have the capacity to **engage in Beyond DV recovery-based programs** and services at one or more of Beyond DV's centres/hubs.

☐ Understand that Beyond DV does **not provide outreach services** and can refer to other appropriate services.

***If all these criteria are not met the referral will be declined**

Client Signature:

Client Name:

Date:

OR **I have received verbal consent from my client to complete and submit this referral (If applicable).**

Worker Signature:

Worker Name:

Date:

What happens next?

A member of the Beyond DV team will be in contact to arrange an Intake meeting. This meeting will be face to face at one of our locations to discuss what Beyond DV can offer and to arrange a goal setting appointment.

For further assistance please call our Carina Office on 0422 723435 to speak with a Beyond DV team member. Visit www.beyonddv.org.au to download a copy of this form.

OFFICE USE ONLY:			
Referral Received Date:		Referral Accepted:	Yes ☐ No ☐
Referral Entered into System:	Yes ☐ No ☐	Date:	
If declined, referred onto:		Date:	