



DFV EXTERNAL AGENCY REFERRAL FORM

DATE:

REFERRING AGENCY DETAILS

Name of referring agency:

Name of referring worker:

Phone:

Email:

Other agencies involved?

Organisation name:

Contact name:

Phone:

CLIENT DETAILS

Client name:

DOB:

Address:

Email:

Contact number:

Best contact time:

Safe to call as DVAC: Yes No

Person Using Violence (PUV) resides with client: Yes No

Safe to leave a message: Yes No

Identifies as: Aboriginal Torres Strait Islander

CALD client: Yes No

Other: Yes No

Interpreter required: Yes No

Primary language:

If yes, what language:

Disability: Yes No

Type:

PUV: Aboriginal Torres Strait Islander CALD Please specify:

Current DVO: Yes No

Previous DVO: Yes No

If yes, please specify conditions:

Recent Police involvement: Yes No

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CHILDREN CONNECTED TO THE CLIENT

Child 1		DOB:	At home:
Gender:		Age:	In care:
Child 2		DOB:	At home:
Gender:		Age:	In care:
Child 3		DOB:	At home:
Gender:		Age:	In care:
Child 4		DOB:	At home:
Gender:		Age:	In care:
Do children have contact with the PUV? Yes No	Current Family Law Orders/parenting arrangements Yes No	Is Child Safety involved? Yes No	Case Plan attached Yes No

IDENTIFIED DOMESTIC FAMILY VIOLENCE RISK FACTORS (PLEASE TICK):

Verbal abuse	Harm to animals/pets	Emotional abuse	Financial abuse
Coercive control	Cultural/spiritual	Technology abuse	Social abuse/isolation
Pending separation	Pregnancy	Recent birth	Stalking/surveillance
Escalation of violence	Severity of violence	Breach of DVO	Threats to kill
Physical abuse/assault	Threats to kill children	Threats to take children away	
Attempts to kill client or children		Intimate partner sexual violence	
Damage to property/willful damage		Attempted strangulation/choking	
Use of, or threats to use weapons		Movements tracked through technology	

IN IPSWICH AREA ONLY Has a referral been made to the High Risk Team? Yes No Date:

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BRIEF DESCRIPTION OF REASONS FOR REFERRAL e.g. Court Support; Home Security Measures; DFV Counselling

What safety planning have you already completed with the client/ family?

Have you made any other referrals to other agencies for this person?

IDENTIFIED RISKS

EMERGENCY CONTACT

Does the person have a safe person we could contact? Yes No

Name:

Relationship:

Contact details:

Referral discussed with client: Yes No

Date consent provided:

(Please note a referral will only be accepted with client consent)

DVAC takes seriously the rights of all clients to confidentiality and privacy of information including the right to remain anonymous if they choose. In particular, we recognise our duty of care to safeguard information which could jeopardize the security and safety of adults, children or young people accessing DVAC services. DVAC is guided by standards of the Australian Privacy Principles regarding the collection, storage, disclosure and use of personal information about individuals.

Please email referral form to:

Ipswich intakeipswich@dvac.org.au
Toowoomba intaketwba@dvac.org.au

Subject line: Referral Form
 Subject line: Referral Form