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*OFFICE USE ONLY* – **FAMILY NUMBER**

**BDASS (Bedford Domestic Abuse Support Service)**

**REFERRAL FORM**

SUPPORTING LOW TO MEDIUM RISK VICTIMS OF DOMESTIC ABUSE

*Please complete all sections or your referral may be returned.*

If this referral is being made on behalf of a family, please note that all referrals must be made with the consent of the family. Please tick to confirm the family have consented to you making this referral □

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| **Information about the parents/carers involved with the child(ren)** | | | | | |
| **Name of Family:** | | | | | |
| **Address (inc post code):** | | **All telephone numbers:** | | | |
| **Relationship to Child(ren)** | **Name, DOB and Ethnic Origin** | | **Main Carer**  **√** | **Parental**  **Responsibility √** | **Resident in family home √** |
| **Mother/Partner** |  | |  |  |  |
| **Father/Partner** |  | |  |  |  |
| **Other Main Carer** |  | |  |  |  |
| **Alleged Perpetrator**  **\***Please also add address if different from above |  | |  |  |  |

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| **Referrer Information** | |
| **Referrer Name:** | **Address (inc postcode)** |
| **Agency:** | **Email:** |
| **Role:** | **Tel:** |
| **Other Agencies Working with the Family** | |
| **Family Doctor Name:**  **Surgery Address:**  **Tel:** | **Name/Role:**  **Agency:**  **Tel:**  **Email:** |
| **Health Visitor:**  **Tel:**  **Email:** | **Name/Role:**  **Agency:**  **Tel:**  **Email:** |
| **Why are you referring the family to FACES?** | |
| ***Does the family give us permission to contact other agencies with a view to supporting them?*** | |
| ***Are there any Health and Safety issues we need to consider?*** | |

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| **Issues Present in Current Situation (please √ all that apply)** | | | | | | | | |
| Lone Parent | Substance Abuse | Domestic Abuse | Mental Health Issues | Learning Disability | Physical Disability | Post Natal Depression | Interpreter Needed | Teen  Pregnancy |

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| **RISK ASSESSMENTS** | |
| **Has the case been heard at MARAC (Multi Agency Risk Assessment Conference) in the last 12 months? If yes, please provide details.** | |
| **SAFELIVES (CAADA RIC)** | |
| **Please note that the completion of a Safelives risk assessment is an essential part of the referral process.** [**Click here**](http://www.safelives.org.uk/sites/default/files/resources/Dash%20without%20guidance%20FINAL.pdf) **for guidance and link to assessment and please attach a copy of the completed assessment to this referral.** | |
| **ASSESSED RISK** | |
| **Using the above assessment tool, is this case considered low, medium or high risk?** | |  |  |  | | --- | --- | --- | | **LOW** | **MEDUIM** | **HIGH** | |  |  |  | |

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| **COURT/CIVIL ORDERS/BAIL CONDITIONS** |
| **Please use this space to indicate if any court orders or civil orders are currently in place.** |

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| **Information about the Child(ren)** | | | | | | | | |
| **No.** | **Name** | | | | **DOB** | | **Gender**  **(M/F)** | **Ethnic Origin (please state)** |
| **C1** |  | | | |  | |  |  |
| **C2** |  | | | |  | |  |  |
| **C3** |  | | | |  | |  |  |
| **C4** |  | | | |  | |  |  |
| **C5** |  | | | |  | |  |  |
| **C6** |  | | | |  | |  |  |
| **Information about any Plans Family are Subject to** | | | | | | | | |
| **Child**  **No.** | | **CAF/EHA (Y/N)** | **TAF/TAC**  **(Y/N)** | **CIN**  **(Y/N)** | **CP**  **(Y/N)** | **Details of Lead Professional (if applicable)** | | |
| **C1** | |  |  |  |  |  | | |
| **C2** | |  |  |  |  |  | | |
| **C3** | |  |  |  |  |  | | |
| **C4** | |  |  |  |  |  | | |
| **C5** | |  |  |  |  |  | | |
| **C6** | |  |  |  |  |  | | |

***Family needs –*** *In order that we can offer the best support, please complete the following table indicating why a family need help in meeting their children’s needs in the areas stated. This information, together with that gathered at initial assessment (which will take place after completed referral form received) serves to inform our tailored plan of support.*

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| **Family Need** | **√** | **If ticked, please state why this is a need** |
| Physical Health |  |  |
| Emotional Wellbeing |  |  |
| Keeping the child(ren) safe |  |  |
| Social Networks |  |  |
| Issues with Education and Learning |  |  |
| Managing Boundaries and Behaviour |  |  |
| Issues with Home and Money |  |  |
| **Parental Need** |  | **If ticked, please state why this is a need** |
| Confidence |  |  |
| Mental Health/Low mood/Anxiety |  |  |
| Risk of Domestic Abuse |  |  |

* We cannot proceed with support until we have received this completed referral form (*which needs to be completed within one calendar month from date of issue*). We will try to respond to you within two weeks to let you know about progress of this referral.
* Self referrals – Our family support practitioners will be in touch to arrange an initial assessment with you at your home where they will discuss with you how best we can support you.
* **For professionals** we will remain in touch whilst we support this family and will let you know when support ends.

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| Parent’s Signature: | Date: |
| Referrer’s Signature:  (if applicable) | Date: |