Referral Form

Wakefield District Domestic Abuse Service (WDDAS)

Secure email address [domesticabuse@wakefield.gov.uk](mailto:domesticabuse@wakefield.gov.uk)

**Central Service 0800 915 1561**

**\*\*\*All fields to be completed, if unknown please state \*\*\***

|  |  |  |
| --- | --- | --- |
| Date of Referral | Victim or Perpetrator | |
|  | Victim  Perpetrator | |
| Has consent been given? | Level of Risk | High risk has the MARAC referral been sent to the MARAC Coordinator? |
| Yes  No | High  Med  Standard | Yes  No |
| How did the client hear about the WDDAS service?  e.g Self / IDVA Car |  | |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Client details | | | Name | | | | | DOB | | | | | Gender identity: | | | |
|  | | | | |  | | | | |  | | | |
| Address | | | | | | | | Postcode | | | | | Safe to Write? | | | |
|  | | | | | | | |  | | | | | Yes  No | | | |
| Accommodation type  e.g WDH, Private, home owner, living with parents/family. | | | | | | | |  | | | | | | | | |
| Landline number | | |  | | | | | Employment status | | | | | | | | |
| Mobile number | | |  | | | | |  | | | | | | | | |
| Are these safe numbers? | | |  | | | | |
| Code word / safe time to call | | |  | | | | | Does the Victim have any substance misuse or mental health issues? | | | | | | | | |
| \*\*\*Sexual orientation \*\*\* | | |  | | | | |  | | | | | | | | |
| \*\*\*Religion \*\*\* | | |  | | | | |
| \*\*\*Nationality / Ethnicity\*\*\* | | |  | | | | | \*\*\*Does the Victim have a disability / literacy or numeracy difficulties? \*\*\* | | | | | | | | |
| Language spoken | | |  | | | | |  | | | | | | | | |
| Translator required | | |  | | | | |
| Forced Marriage | | |  | | | | | \*\*\*Relationship Status \*\*\*  e.g. married/ separated/ living together | | | | | | | | |
| Immigration status and any concerns | | |  | | | | |  | | | | | | | | |
| Are there any legal orders in place? e.g. Restraining Order etc | | |  | | | | |
| Reason and circumstances for Referral (please provide all relevant information) | | | **\*\*\*\*Must be completed with reason for referral and DASH attached \*\*\*\*** | | | | | | | | | | | | | |
| Freedom Programme Perpetrator Programme | | | Yes  No  Yes  No | | | | | | | | | | | | | |
| Children’s Details | | | | | | | | | | | | | | | | |
| Children’s details Name | Gender | | | DOB/ age | Relationship | | | | | | | Does (ex) partner have PR? | | | | School / Nursery |
| Victim | | | | Perpetrator | | |
|  |  | | |  |  | | | |  | | | Yes  No | | | |  |
|  |  | | |  |  | | | |  | | | Yes  No | | | |  |
|  |  | | |  |  | | | |  | | | Yes  No | | | |  |
|  |  | | |  |  | | | |  | | | Yes  No | | | |  |
|  |  | | |  |  | | | |  | | | Yes  No | | | |  |
| Is the client pregnant? | | | | Yes  No | | | | | | Due Date | | | |  | | |
| Where are the children residing. Please state address (if different to client details above) | | | |  | | | | | | | | | | | | |
| Has a referral been made to CYPS / describe involvement and contact details of worker | | | |  | | | | | | | | | | | | |
| Flag significant concerns regarding children. | | | |  | | | | | | | | | | | | |
| Other agencies | | | | | | | | | | | | | | | | |
| What other agencies are involved | | | |  | | | | | | | | | | | | |
| Medical Details | | | | | | | | | | | | | | | | |
| GP Name and Surgery details | | | |  | | | | | | | | | | | | |
| Is the client currently on any prescribed medication? | | | | Yes  No | | Please specify: | | | | | | | | | | |
| Others involved (Partner/ ex-partner/ family member details)  Perpetrator of Victim | | | | | | | | | | | | | | | | |
| Perpetrator  Victim | | Name | | | | | | | | | DOB | | | | Gender Identity | |
|  | | | | | | | | |  | | | |  | |
| Address | | | | | | | | | | | Postcode | | | | Ethnicity | |
|  | | | | | | | | | | |  | | | |  | |
| Employment Status | | | | | | |  | | | | | | | | | |
| Does the Perpetrator have any substance misuse or mental health issues? | | | | | | |  | | | | | | | | | |

|  |  |
| --- | --- |
| Referring Agency | |
| Refers Name |  |
| E-mail address |  |
| Telephone number |  |

**For Office Use Only**

|  |  |
| --- | --- |
| **Checklist** | |
| SafeLives Dash risk checklist completed | Yes  No |
| Risk Level | High  Med  Stand |
| ISSP in place | Yes  No |
| Confidentiality and information sharing agreement consented to by client | Yes  No  Written  Telephone |
| Service explanation provided | Yes  No  Written  Telephone |
| Is there a conflict of interest in this case? | Yes  No  If yes, discuss with your manager |
| Is this a repeat | Yes  No |
| **Other** | |
|  | |