**Havering Domestic Abuse Perpetrator Intervention Professionals Referral Form**

Please return the form to EMAIL adminDVA@cranstoun.org.uk for info: 07825-009115

If you are using the CJSM secure mechanism you are not required to password protect the document. If you are using non secure email please password protect your document and notify us of the password in a separate email. Please do not include the password in the same email as the document you are sending.

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| **Referrer Details** |
| Name of Referrer |  | Date of Referral |  |
| Position |  |
| Name of Organisation |  |
| Contact Details Telephone/email |  |
| **CONSENT****Please confirm that consent has been given by the Victim and/or perpetrator for this referral.** | **VICTIM**Yes[ ]  No[ ] **PERPETRATOR**Yes[ ]  No[ ]  |
| **Victim Details** |
| First Name |  |  Date of Birth  |  |
| Surname |  |  Age |  |
| Address |  |
| Telephone Number(s) |  |  Email |  |
| Safe to call / text / leave voicemail (please give details) |  |
| Pregnant |  Yes [ ]  No [ ]  Estimated Date of Delivery (EDD): |
| Ethnicity |  |
| Disability |  Yes [ ]  No [ ]  Details: |
| Sexual Orientation |  |
| Gender Identity |  |
| Substance Misuse | Yes [ ]  No [ ]  Details:  |
| Mental Health Issues | Yes [ ]  No [ ]  Details:  |
| Is the victim a repeat victim? | Yes [ ]  No [ ]  Details:  |

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|  **Perpetrator Details** |
| First Name |  |  Date of Birth |  |
| Surname |  |  Age |  |
| Address |  |
| Telephone Number(s) |  |  Email |  |
| Ethnicity |  |
| Disability |  |
| Sexual Orientation |  |
| Gender Identity |  |
| Substance Misuse | Yes [ ]  No [ ]  Details:  |
| Mental Health Issues | Yes [ ]  No [ ]  Details:  |
| Any current court involvement? | Yes [ ]  No [ ]  Details:  |

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| **Other Agencies Involved** | **Details** |
| Health Visitor | Yes [ ]  No [ ]  Details:  |
| Criminal Justice/Probation | Yes [ ]  No [ ]  Details:  |
| Mental Health Services | Yes [ ]  No [ ]  Details:  |
| Other Health Services | Yes [ ]  No [ ]  Details:  |
| Other |  |

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| **Child/ren Details** |
| **Name** | **M/F** | **DOB** | **Age** | **Ethnicity** | **Relationship to Child** | **Name of School or College** |
| **Victim** | **Perpetrator** |
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| **If living elsewhere, please give details:** |
| **Child** | **Name of Carer** | **Relationship** | **Address** |
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| **Current Children’s Services Involvement** | Child in Need |  Yes [ ]  No [ ]  |  Date started |  |
| Local Authority |  |  | Child Protection |  Yes [ ]  No [ ]   |  Date started |  |
| Social Worker |  |  | Any other legal orders in place |  |

| **Reason for referral, case history and any other relevant information:** |
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***Please ensure all referral forms sent via non-secure email method are password protected. Passwords should be sent to us in a separate email to meet safeguarding protocol and ensure data breeches are not made. Please note this is a controlled document. Any printed copies of this document are not controlled.***