*Please complete with as much information as possible (leave boxes blank if not applicable)*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Location: (Please tick)** | **Shropshire** |  | **Telford & Wrekin** |  | **Our Ref:** |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Referrer Information:** | | | | | | | | **Police Referrals Only:** | | | | | | | | | |
| Agency Referring: | | | | | | | | OIC Contact: | | | | | | | | | |
| Date of Referral: | | | | | | | | OIC Email: | | | | | | | | | |
| Person Referring: | | | | | | | | OIC Direct Line: | | | | | | | | | |
| Referrers Email: | | | | | | | | OIS Incident Log Ref: | | | | | | | | | |
| Referrers Direct Line: | | | | | | | | Crime Ref No: | | | | | | | | | |
| **Client Information: (For Yes/ No answers, please delete)** | | | | | | | | | | | | | | | | | |
| Surname: | | | | | Title: Mr/Mrs/Miss/ Other………........ | | | | | | | | | DOB: | | | |
| Forenames: | | | | | | Ethnic group: | | | | | | | | | | | |
| Preferred Name: | | | | | | First Language: | | | | | | | | | | | |
| Address:  Postcode:  **Safe to write?** Yes/ No | | | | | | Interpreter Required: Yes/ No | | | | | | | | | | | |
| **Mobile No:** **Safe to call?** Yes/ No  **Ok to leave message?** Yes/ No **Ok to text?** Yes/ No  **Landline No:** **Safe to call?** Yes/ No  **Ok to leave message?** Yes/ No **Ok to text?** Yes/ No  **Email address:**  **Safe?** Yes/ No | | | | | | | | | | | |
| **Any additional vulnerabilities: (please delete)** | | | | | | | | | | | | | | | | | |
| **Learning Difficulties** Yes/No | | | | | | | | | **Physical Disability** Yes/ No | | | | | | | | |
| **Substance Misuse** Yes/No | | | | | | | | | **Self-Injury** Yes/ No | | | | | | | | |
| **Mental Health Issues** Yes/ No | | | | | | | | | **Homeless** Yes/ No | | | | | | | | |
| Other: | | | | | | | | | | | | | | | | | |
| **Is the client pregnant?** Yes/ No How many weeks? | | | | | | | | | | | | | | | | | |
| Is the client involved with other voluntary/statutory agencies: Yes/ No  If yes please name the agency or workers involved: | | | | | | | | | | | | | | | | | |
| **Attended Sexual Assault Referral Centre (SARC):** Yes **/** No **Forensic Medical Examination?:** Yes/ No **Date:** | | | | | | | | | | | | | | | | | |
| Any other relevant information: (If this referral if for a child or young person – please provide the name of the Parent/ Carer and their contact details below) | | | | | | | | | | | | | | | | | |
| **Children** | | | | | | | | | | | | | | | | | |
| Does the client have children? | | | | | | | | Yes/ No | | | | | | | | | |
| **Child’s name** | | | | | | | | **DOB** | | | | | **Male or female (please delete)** | | | | |
|  | | | | | | | |  | | | | | Female/ Male | | | | |
|  | | | | | | | |  | | | | | Female/ Male | | | | |
|  | | | | | | | |  | | | | | Female/ Male | | | | |
|  | | | | | | | |  | | | | | Female/ Male | | | | |
| Do any of the children have a child protection plan or have they been referred to Children’s Services?  Detail: | | | | | | | | | | | | | Yes/ No | | | | |
| **Incident(s) - Please indicate which category or categories best fit what has happened by putting an x in the box(es)** | | | | | | | | | | | | | | | | | |
| Rape | | |  | Attempted rape | | | | | |  | Multiple Assailant Rape | | | | |  | |
| Assault by penetration | | |  | Sexual Assault | | | | | |  | Sexual Touching | | | | |  | |
| Childhood Sexual Abuse | | |  | Child sexual exploitation | | | | | |  | Online Sexual offences | | | | |  | |
| Sexual Violence | | |  | Suspected drug facilitated | | | | | |  | Not known | | | | |  | |
| Date of Incident: | | | | | | | | | | Location of Incident: | | | | | | | |
| Brief details of incident: | | | | | | | | | | | | | | | | | |
| **Suspect details (if known):** | | | | | | | | | | | | | | | | | |
| **Name:** | | | | | | | | | **D.O.B:** | | | | | | | | |
| **Bail conditions:**  **Bail date (if known):** | | | | | | | | | | | | | | | | | |
| **Relationship to client: (please indicate with an x in the relevant box)** | | | | | | | | | | | | | | | | | |
| Partner |  | Ex-partner | | | | |  | | Relative (s) | | |  | | | Acquaintance\* | |  |
| Stranger 1\*\* |  | Stranger 2 \*\*\* | | | | |  | | Gang Related | | |  | | | Unknown | |  |
| \*Acquaintance = friends, colleagues, neighbours, step/foster family , i.e. known to the survivor over a period of time  \*\* Stranger 1 = perpetrator makes a sudden attack without prior notice  \*\*\* Stranger 2 = Perpetrator makes contact before the assault eg buys a drink, starts a conversation but is not otherwise known to survivor | | | | | | | | | | | | | | | | | |
| **Domestic Abuse Related Incidents:** | | | | | | | | | | | | | | | | | |
| Has a DASH assessment been completed? Yes/ No  If yes, please attach/forward a copy of the DASH assessment | | | | | | | | | | | | | | | | | |
| **Are there any issues concerning safety that staff need to be aware of?** | | | | | | | | | | | | | | | | | |
| **Clients Consent:** | | | | | | | | | | | | | | | | | |
| **I agree to being referred to the ISVA Service**  **Signature of Client............................................................................... Date…………………………**  **If unable to obtain a signature please confirm that verbal consent has been given Yes/ No**  **Date…………………………………………….** | | | | | | | | | | | | | | | | | |

**Please forward securely to:** [isva.service@axis.cjsm.net](mailto:isva.service@axis.cjsm.net)

**Or if you do not have access to secure email, password-protect the referral and email to:** [isva@axiscounslling.org.uk](mailto:isva@axiscounslling.org.uk) **and contact us separately with the password.**

**Shropshire: 01743 243007 Telford & Wrekin: 01952 586790**