DOMESTIC VIOLENCE ACTION CENTRE
DVAC
SERVICE AGAINST SEXUAL VIOLENCE

**IPSWICH**
**T** 07 3816 3000

**TOOWOOMBA**
**T** 07 4642 1354

PO Box 864, Booval Fair Q 4304
DVACIpswichAndToowoomba
**www.dvac.org.au**

# 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
If yes, please specify conditions:

Previous DVO: ◯ Yes ◯ No
Recent Police involvement: ◯ Yes ◯ No

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## DFV EXTERNAL AGENCY REFERRAL FORM /2

### 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<br>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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# DFV EXTERNAL AGENCY REFERRAL FORM /3

## 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 download this form and fill it in, then email manually or click on the appropriate button to submit via email.
(Please note: submit buttons will not work online, form must be downloaded first.)

| | | |
|---|---|---|
| **Ipswich** | intakeipswich@dvac.org.au | Subject line: Referral Form |
| **Toowoomba** | intaketwba@dvac.org.au | Subject line: Referral Form |

Submit: Ipswich
Submit: Toowoomba