



Ipswich  
[07 3816 3000](tel:0738163000)  
Toowoomba  
[07 4642 1354](tel:0746421354)

## Referral

Referral 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

Other: Yes No

CALD client: Yes No

Other: Yes No

Interpreter required: Yes No

Primary language:

If yes, what language:

Disability: Yes No

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Current DVO: Yes No

Previous DVO: Yes No

If yes, please specify conditions:

Recent Police involvement: Yes No





**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	
		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	7 H F K Q R D E X V H	Social abuse/isolation
Pending separation	Pregnancy	Recent birth	Stalking/surveillance
Escalation of violence	Severity of violence	Breach of DVO	7 K U H D W R L O O
Physical abuse/assault	7 K U H D W R L O O G U H Q		7 K U H D W R L O O G U H Q
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** K D V D U H I H E U D I D G W R L J K L V N H D P < H V 1 R ' D W H



**BRIEF DESCRIPTION OF REASONS FOR REFERRAL** e.g. Court Support ; Home Security Measures; DFV Counselling

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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**

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**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 )

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Ipswich            intakeipswich@dvac.org.au  
Toowoomba      intaketwamba@dvac.org.au

Subject line: Referral Form  
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