THE CENTRE FOR WOMEN & CO.

Specialist Domestic Violence & Women's Wellbeing Services

EXTERNAL AGENCY REFERRAL FORM

PLEASE TICK THE BOXES FOR THE AREA AND SERVICE YOU ARE REFERRING INTO

DFV Support Women's Generalist Counselling SV Support Child & Youth DFV Counselling Groups

SECTION A: CLIENT INFORMATION – This section *MUST* be completed for the client (*please note the client is the parent/guardian/carer of child/young person being referred*). Date of referral

The client consents to and is aware this referral is being sent to The Centre for Women & Co. Yes No

Please do not proceed until you have consent.

Client's full name DOB Age

Gender Preferred pronouns

Address Suburb

Phone numbers Email

Is it safe to: Call? Yes No Text? Yes No Voicemail? Yes No Email? Yes No Mail? Yes No

If no, please provide further information:

Do you identify as Aboriginal Torres Strait Islander Both Neither CALD

Country of birth Interpreter required? Yes No

If yes please provide preferred language

Emergency contact name & number Relationship to client

Details of any other agencies involved i.e. child safety, housing etc

Domestic Violence Order Yes No Family Court Orders Yes No Parenting Plan Yes No

If you ticked yes to any of the above, please attach with this referral.

Person using violence (PUV) name PUV gender

PUV date of birth PUV relationship to client

PUV Address Does the PUV live with the client? Yes No

Child/Young Person Details (if any) i.e. name, DOB and relationship to PUV: Are they named on DVO Yes No

SECTION B - WOMEN'S DFV SUPPORT, HARA-SV SUPPORT OR WOMEN'S GENERALIST COUNSELLING

Please note HARA-SV referrals can be for victim-survivors of any age and gender. At this time, hara-sv referrals are only open to the qld health social work team.

Please outline what support the client is seeking, primary concern, and other information including wellbeing, mental health, recent acts of violence, safety concerns, PUV's pattern of behaviour, other risk factors and vulnerabilities to take into consideration.

SECTION C - GROUPS

WHICH GROUP/S IS THE CLIENT INTERESTED IN?

Flourish Ignite RISE Healing Together Kickstarter

Comments/Other:

SECTION D: CHILD & YOUTH DFV COUNSELLING

THIS SECTION MUST BE FILLED OUT TO REFER A CHILD OR YOUNG PERSON TO DFV COUNSELLING. PLEASE COMPLETE ONE FORM FOR EACH CHILD/YOUNG PERSON BEING REFERRED.

Criteria for engagement in Child and Youth Domestic and Family Violence Counselling is as follows:

- *Child/young person has experienced/witnessed or is at risk of experiencing DFV.*
- *Non-offending parent/guardian can attend a face-to-face intake and assessment meeting with the C&Y DFV Counselling Team to determine if specialist CY DFV Counselling is the most appropriate service for the child/young person.*
- *Child/young person can attend weekly, one-hour appointments at Beenleigh/Redlands.*

Child/young person's name Child/young person's DOB

Does the child/young person identify as Male Female Non-Binary Other

Preferred pronouns He/Him She/Her They/Them Other

Does the child/young person identify as Aboriginal Torres Strait Islander Both Neither CALD

Medical conditions or diagnoses

ASD ADHD Intellectual Impairment Development Delay (including speech and language)

Physical Impairment Medical Alert (asthma/allergies)

Further Comments

Please provide details of the pattern of abuse PUV used to directly harm the child/young person

Physical Verbal Coercive control Emotional Witness to drug misuse Threats to harm/kill (made to child) Threats of PUV suicide (known by child) Witnessed DFV in the home

Further Comments

Please provide details of the current behaviours exhibited by the child/young person due to the impact of the DFV:

Physical aggression Verbal aggression Withdrawal Anxiety Depression School refusal/ attendance problems Academic difficulties Peer/social difficulties Self-esteem issues Sexualised behaviour Sleeping difficulties/nightmares Suicidal ideation/attempt/s

Further Comments

Please provide details of the impact on family functioning due to the DFV:

Attachment rupture with non-offending parent Sibling conflict Isolation/estrangement from extended family Parentification Defensive/protective of non-offending parent

Further Comments

ORGANISATIONAL REFERRER'S DETAILS

Name Service

Phone number Email

Do you need to be notified of the outcome of referral? Yes No

Documentation attached? Yes No

Does the client want a family or friend involved in the assessment process? If so, please provide the family or friend's details below (name and contact information).

For any group program referrals, please email directly to Groups@centreforwomen.org.au

For any HARA-SV referrals, please email directly to HARA-SV@centreforwomen.org.au

For all other referrals, please email directly to Intake@centreforwomen.org.au