**hT: 01225 420249   
T: 07523 506239  
EMAIL REFERRALS TO:  
info@voicescharity.org**

Referral Form

|  |
| --- |
| ABOUT YOU |
| First name: |
|  |
| Last name: |
|  |
| Date of birth: |
|  |
| Ethnicity: |
|  |
| Preferred language: |
|  |
| GP’s name and surgery: |
|  |
| Do you consider yourself to have a long term disability, health issues (including mental health) or learning difficulties? |
| Yes  No |
| If ticked ‘Yes’ then please provide details: |
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|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| CONTACT DETAILS | | | | | | | |
| Address: | | | | | | | |
|  | | | | | | | |
|  | | | | | | | |
|  | | | | | | | |
| Postcode: |  | | | | | | |
| Best telephone number to contact you: | | | | | | | |
|  | | | | | | | |
| Is this number safe to contact you at all times? | | | | | Yes  No | | |
| Can we leave a voicemail or text this number? | | | | | Yes  No | | |
|  | | | | | | | |
| Email address: | | | | | | | |
|  | | | | | | | |
|  | | | | | | | |
| EMPLOYMENT STATUS | | | | | | | |
| Please tick **one** of the below: | | | | | | | |
| Employed under 16 hours  Employed over 16 hours  Self employed under 16 hours  Self employed over 16 hours  Unemployed  Economically inactive\*  \*Economically inactive means: of working age but not employed,  not self-employed, not actively seeking work and not in full time education. | | | | | | | |
| Length of unemployment / economic inactivity (if selected above): | | | | | | | |
| Years | |  | Months |  | |  |  |
|  | | | | | | | |
| BRIEF HISTORY OF DOMESTIC ABUSE | | | | | | | |
| Types of Abuse Experienced: | | | | | | | |
| Physical  Emotional  Financial  Sexual  Psychological  Coercive control | | | | | | | |
| Are you still in the relationship? | | | | | | | |
| Yes  No | | | | | | | |
| If ‘No’ then please specify time out of relationship: | | | | | | | |
|  | | | | | | | |
|  | | | | | | | |
| PERPETRATOR’S DETAILS | | | | | | | |
| First name: | | | | | | | |
|  | | | | | | | |
| Last name: | | | | | | | |
|  | | | | | | | |
| Date of birth: | | | | | | | |
|  | | | | | | | |
| Is the perpetrator living within the BANES area? | | | | | | | |
| Yes  No | | | | | | | |
| If ‘Yes’ then do you know which area? | | | | | | | |
|  | | | | | | | |
| Are you still living with the perpetrator? | | | | | | | |
| Yes  No  Sometimes | | | | | | | |
|  | | | | | | | |
| SUBSTANCE MISUSE | | | | | | | |
| Do you identify as having any substance use issues? | | | | | | | |
| Yes  No | | | | | | | |
| If ‘Yes’ then please give further details: | | | | | | | |
| Drugs  Alcohol  Other | | | | | | | |
| Are you receiving any help or support with these issues? | | | | | | | |
| Yes  No  No, but would like some | | | | | | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| CHILDREN’S DETAILS | | | | |
| Child’s name | Child’s DOB | Name of person child living with | Their relationship to the child | On ‘At Risk’ / ‘Child in Need’ |
|  |  |  |  | Yes  No |
|  |  |  |  | Yes  No |
|  |  |  |  | Yes  No |
|  |  |  |  | Yes  No |
|  |  |  |  | Yes  No |

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| WHAT PROGRAMME(S) ARE YOU INTERESTED IN: |
| Freedom  MATES  Recovery Toolkit |

|  |  |  |
| --- | --- | --- |
| Do you require childcare for your child/ren to access the programme(s)?  (There is a crèche option for Freedom Programme and Recovery Toolkit.) | | |
| Yes  No | | |
| Please state the following: | | |
| Child’s name | Child’s age | Does the child have any additional needs? (please specify) |
|  |  |  |
|  |  |  |
|  | | |
| LEGAL PROTECTION / PROCEEDINGS IN PLACE? | | |
| Are there any court orders currently in place relating to any family members?  (adult or children) | | |
| Yes  No | | |
| If ‘Yes’ then please give details: | | |
|  | | |
|  | | |
| EXTERNAL AGENCY INVOLVEMENT | | |
| Have the police been involved? | | |
| Yes  No | | |
| If ‘Yes’ then when was the last time? (month/year) | | |
|  | | |
| Are you or your family under MARAC (Multi-agency Risk Assessment Conference)? | | |
| Yes  No | | |
| Are you currently receiving support from any other agencies? | | |
| Yes  No | | |
| If ‘Yes’ then tick all that apply: | | |
| Victim Support  Southside IDVA Service  Southside Family Service  Next Link  DHI  Social Services  CAFCASS  Connecting Families  Bath Area Play Project (BAPP)  Trauma Recovery Centre (TRC)  Off The Record  Private Counselling  BANES Talking Therapies  New Way  GP  Probation  CPS  Midwife / Health visitor  School Nurse  Mental HealthTeam | | |
| Please detail any not listed: | | |
|  | | |

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| --- | --- | --- | --- |
| REFERRAL | | | |
| Is this a self-referral? | | | |
| Yes  No | | | |
| If ‘No’ then please provide name of referring agency/person: | | | |
| Agency | Professional’s name | Telephone number | Email |
|  |  |  |  |

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| CLIENT CONSENT |

I ………………………………….. have checked that the information on this form is accurate and consent to Voices holding these details. I understand my information will be kept securely and confidentially and stored on Voices database in accordance with the Data Protection Act.

Voices will not pass information on to any other parties without consent except in the case of a serious safeguarding concern.

I consent to Voices sharing information relevant to my support with the referring agency :

Yes/ No/ NA

I consent to Voices sharing information with the other agencies supporting me (and listed above)

Yes/ No/ NA

Client Signature:

Date:

|  |
| --- |
| ANY ADDITIONAL NOTES OF INFORMATION (OPTIONAL) |
| NOTES: |
|  |

VOICES – PO BOX 5184, Bath, BA1 0RZ.

Registered Charity 1159445.

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