**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 |

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| 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 |

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| 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.

T: 01225 420249 / 07523 506239

E: info@voicescharity.org W: www.voicescharity.org

T: voices\_charity F: facebook.com/voicescharity