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| **Agency information** | | | |
| Agency making referral |  | Contact name |  |
| Contact telephone |  | Contact email |  |
| What is your involvement with the referral? |  | | |

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| **Client information** | | | | | | | | | | |
| Date of Referral: | |  | | Form Completed By | | | |  | | |
| **Client Details** | | | | | | | | | | |
| Client Name: |  | | | | Date of Birth: | |  | | | |
| Landline:  Mobile: | Safe to Call: Yes/No | | | | Address:  Postcode: | | Safe to write: Yes/No | | | |
| Give details of any disability: |  | | | | Ethnicity: | |  | | | |
| Religion: | |  | | | |
| **Children and Family** | | | | | | | | | | |
| Name Of Child | | | M/F | | | Date of Birth | | | Living With Client (Y/N) | |
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| **Perpetrator information** | | | | | | | | | |
| |  |  |  |  | | --- | --- | --- | --- | | Perpetrator name |  | Date of birth |  | | Additional risks/concerns |  | | | | | | | | | | | | |
| **Reason for the referral** | | | | | | | | | |
| **What is the main reason for the referral to Black Country Women’s Aid?**  **Brief Overview of Situation (include background to case, previous history, analysis of risk, current relationship status and living situation)**  **Which GP Surgery do you attend?**  **For young people under the age of 18**  **Name of school/college:**  **Parents contact details (Name/number)** | | | | | | | | | |

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Where possible form should be sent to [referral.team@sandwellwa.cjsm.net](mailto:referral.team@sandwellwa.cjsm.net)

Non secure emails can be sent to [idva@blackcountrywomensaid.co.uk](mailto:idva@blackcountrywomensaid.co.uk) as a last resort only and should be password protected.