**ISVA Referral Form**

**Please complete ALL fields**

|  |  |
| --- | --- |
| **Client’s Name:** |  |
| **Date of birth:** |  |
| **Client Address:** |  | [ ]  **Safe to send letters?** |
| **Client Landline:** |  |  | [ ]  **Safe to call?**[ ]  **Safe to leave VM?** |
| **Client Mobile:** |  |  | [ ]  **Safe to call?**[ ]  **Safe to text?**[ ]  **Safe to leave VM?** |
| **Client email address:** |  |  | [ ]  **Safe to email?** |
| **Alternative person to contact and details:** |  |
| **Preferred method of contact:** |  |
|  |
| **Does the client require any other Safeline Service?**  | [ ]  **1 - 1 Counselling** [ ]  **Online/Telephone Counselling (Male clients only)** [ ]  **Young People’s Projects**[ ]  **1-1 Young People’s Programme** |
| **Other services/agencies /organisations involved with care?** |  |
| **Any medical conditions we should be aware of?** |  |
| **Medication?** |  |
| **Reason for referral to the ISVA service:** |  |
| **Are there any apparent risks to this person for example: Suicide, self-harm, issues around drug or alcohol use** **If yes please give details and enclose relevant documentation or care plans.** |  |
| **Are there any apparent risks to other people for example: Criminal convictions, aggressive or abusive behaviours whether verbal or physical towards staff/others****If yes please give details and enclose relevant documentation or care plans.** |  |
| **Please add any other information that you feel may be relevant.** **i.e. Crime reference number** |  |

**For your information**

Once we have received this referral we will always attempt to contact the client within a 24-hour period during business hours. The type of contact will depend on the permissions given by the client. If we are unsuccessful in our first attempt we will try to make contact again via phone/text/email over a 3-week period. By the end of the 3 weeks if we are still unsuccessful we will send an information package via email or post for them to make their own choice to contact us.

**Referrer details**

|  |  |
| --- | --- |
| **Agency/Organisation Name:**  |  |
| **Form completed by:** |  |
| **Contact number:** |  |
| **Email:** |  |
| **Date completed:** |  |
| **Client’s consent for referral and for us to contact them:** | [ ]  **Yes** [ ]  **No** |

**Please return this form via secure email to** **jarin.dyke@safelinewarwick.cjsm.net**

**For all general enquiry’s please call the office on 01926 402498 or email** office@safeline.org.uk

**Safeline**

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[www.safeline.org.uk](http://www.safeline.org.uk)

[www.slyp.org.uk](http://www.slyp.org.uk)