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**ISVA SERVICE REFERRAL FORM**

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| **REFERRING AGENCY** |
| **AGENCY** |  | **PHONE** |  |
| **CRN/URN** |  | **EMAIL** |  |
| **FORM COMPLETED BY** |  | **PHONE** |  | **DATE** |  |

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| **RECEIVING AGENCY** |
| **AGENCY** | SAFELINE | **PHONE** | 01926 402 498 |
| **SERVICE** | ISVA | **EMAIL** | **ISVA@safeline.org.uk****ISVA@safelinewarwick.cjsm.net**  |

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| **CLIENT INFORMATION** |
| **LAST NAME** |  | **FIRST NAME**  |  |
| **DATE OF BIRTH** |  | **FEMALE/MALE/OTHER** |  |
| **INTERPRETER REQUIRED?** |  | **GUARDIAN NAME** ***if applicable*** |  |
| **LANGUAGE REQUIRED** |  | **GUARDIAN RELATIONSHIP *if applicable*** |  |
| **CLIENT ADDRESS** |  | **CONTACT PHONE NUMBER**  |  |
|  |  | **EMAIL** |  |
|  |  | **IS IT OK TO:** | [ ]  Voicemail [ ]  Text [ ]  Email[ ]  Post |
| **PREFERRED CONTACT METHOD** | [ ]  Telephone [ ]  Email[ ]  Post | **WHO DO THESE CONTACT DETAILS BELONG TO?** |  |
| *Additional information for funding purposes only - if the client would prefer not to say then please leave blank* |
| SEXUALITY: | ETHNICITY: |

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| **OTHER SERVICES REQUESTED:**[ ]  **Counselling (face-to-face)**[ ]  **Online and telephone counselling (anyone 16+ who has experienced childhood sexual abuse)**[ ]  **Prevention and Early Intervention (one-to-one work in primary & secondary schools)** |
| **REASON FOR REFERRAL** | *(E.G. Advocacy issues, brief details of offence, suspect name and relationship to victim, has suspect been arrested, is suspect on bail/remand?)* |
| **IS THE CLIENT AWARE OF THIS REFERRAL? IF NOT, PLEASE EXPLAIN.**  |  |
| **DOES THE CLIENT HAVE ANY OTHER SERVICES INVOLVED IN THEIR CARE?** |  |
| **DOES THE CLIENT HAVE ANY MEDICAL CONDITIONS WE SHOULD BE AWARE OF?** |  |
| **DOES THE CLIENT HAVE ANY DISABILITY SUCH HAS MENTAL HEALTH, LEARNING OR PHYSICAL?** |  |
| **ARE THERE ANY APPARENT RISKS SUCH AS SELF HARM, SUICIDE, DRUG OR ALCOHOL MISUSE?** |  |
| **ARE THERE ANY APPARENT RISKS TO OTHER PEOPLE?** |  |
| **ADDITIONAL COMMENTS** |  |

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| **CONSENT TO RELEASE INFORMATION** Read with client / caregiver and answer any questions before obtaining signature. |
| The signature below serves to authorise that the client understands that the purpose of the referral and disclosure of information to the agency listed above is to ensure the safety and continuity of care among service providers seeking to serve the client. The referring agency has clearly explained the procedure of the referral to the client and has listed the exact information that is to be disclosed. By signing this form, the client authorises this exchange of information and gives consent for Safeline to store and process their personal information in line with the General Data Protection Regulation (GDPR) of the Data Protection Act 2018.  |
| **CLIENT SIGNATURE (VERBAL/WRITTEN)** |  | **CAREGIVER SIGNATURE****(VERBAL/WRITTEN)** |  | **DATE** |  |

Please return this form to **ISVA@safeline.org.uk** or **ISVA@safelinewarwick.cjsm.net** (secure email)

For all general enquiries please call the office on 01926 402 498

Safeline

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Warwick

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