

LBTH DOMESTIC VIOLENCE REFERRAL & MONITORING FORM

This form must be used to record ALL reports of DV within Tower Hamlets and to make referrals to local DV services, only with the victim's consent. It must be copied to the LBTH DV Team for monitoring and review. It provides essential information to assist agencies to support the client, and reduces the need to repeat information to different staff. The completed form **must** be faxed to the DV Team on **020 7364 4299**. For advice phone **0800 279 5434** or Email domesticviolence@towerhamlets.gov.uk

**LBTH DV1
CONFIDENTIAL**

REFERRER'S DETAILS				
Referral Agency:	Name:	Phone:	Date:	Your Reference:

CLIENT'S DETAILS				
First Name/Initial:	Middle Name/Initial	Surname:	Date of Birth: <small>Click here to enter a date.</small>	Gender: Female <input type="checkbox"/> Male <input type="checkbox"/> Transgender <input type="checkbox"/>
Current Address:		Living with the perpetrator? Yes <input type="checkbox"/> No <input type="checkbox"/>	Is it safe to write to the client at this address? Yes <input type="checkbox"/> No <input type="checkbox"/>	Safe contact number: Ok to leave message? Yes <input type="checkbox"/> No <input type="checkbox"/>
Postcode:				Safe time(s) to contact:

Is this an out of borough referral? Yes No
If yes, please ensure an appropriate referral has been made to specialist support services in the other borough

Housing tenure:	Sole tenant <input type="checkbox"/> Landlord:	Joint tenant <input type="checkbox"/> Landlord:	Partner is sole tenant <input type="checkbox"/> Landlord:	Owner Occupier <input type="checkbox"/>	Other (please state)
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How does the client define their:	Sexual orientation <small>Click to Select.</small>	Ethnicity <small>Click to Select.</small>	Faith <small>Click to Select.</small>
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Does the client consider themselves disabled Yes <input type="checkbox"/> No <input type="checkbox"/> <small>If yes, please specify access needs:</small>	Language support needed Yes <input type="checkbox"/> No <input type="checkbox"/> <small>If yes, please specify:</small>	No recourse to public funds case Yes <input type="checkbox"/> No <input type="checkbox"/>
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PERPETRATOR

Relationship with perpetrator:	<input type="checkbox"/> Husband/Wife/Civil Partnership <input type="checkbox"/> Ex-husband/wife/Civil Partnership <input type="checkbox"/> Partner <input type="checkbox"/> Ex-Partner	<input type="checkbox"/> Parent/Step Parent/Guardian <input type="checkbox"/> Son/daughter <input type="checkbox"/> Brother/sister	<input type="checkbox"/> Acquaintance <input type="checkbox"/> Friend <input type="checkbox"/> Other <i>Please specify:</i>	Perpetrator's Gender: Female <input type="checkbox"/> Male <input type="checkbox"/> Transgender <input type="checkbox"/>
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Perpetrator's Name:	First: Surname:	Perpetrator's Address:	Perpetrator Date of Birth:	<small>Click here to enter a date.</small>
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CHILDREN

Children Living in the Home Yes <input type="checkbox"/> No <input type="checkbox"/>	Currently pregnant? Yes <input type="checkbox"/> No <input type="checkbox"/>	How many children (aged 17 or under) live with the client?	Children's Social Care informed? Yes <input type="checkbox"/> No <input type="checkbox"/>	Merlin Created? (Police use only) Yes <input type="checkbox"/> No <input type="checkbox"/> Number:
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Name(s) of any children:		Dates of birth	

REFERRAL DETAILS

Which VAWG Strand does this referral relate to? <small>Please tick all that apply</small>	<input type="checkbox"/> Domestic violence <input type="checkbox"/> Sexual Violence <input type="checkbox"/> Sexual Exploitation	<input type="checkbox"/> Female Genital Mutilation <input type="checkbox"/> So-called 'Honour' based violence <input type="checkbox"/> Forced Marriage	<input type="checkbox"/> Stalking <input type="checkbox"/> Harassment <input type="checkbox"/> Trafficking	<input type="checkbox"/> Dowry Abuse
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How long has the abuse been occurring? _____ Years _____ Months

Are you making a Third Party Report? Yes <input type="checkbox"/> No <input type="checkbox"/>	Has the client given consent for this? Yes <input type="checkbox"/> No <input type="checkbox"/>
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PLEASE FAX THIS FORM TO THE AGENCY YOU ARE REFERRING TO AND TO LBTH DV TEAM ON 020 7364 4299 or Email: domesticviolence@towerhamlets.gov.uk

MOST RECENT INCIDENT DETAILS

Incident Date:	Where did it happen? <input type="checkbox"/> Client's home <input type="checkbox"/> Perpetrator's home <input type="checkbox"/> Other (please specify)
Incident Details: Please briefly describe the <i>most recent</i> incident	
Medical Attention Needed? <input type="checkbox"/> Hospital <input type="checkbox"/> GP <input type="checkbox"/> Dentist <input type="checkbox"/> Other (please specify)	Reported to the Police? Yes <input type="checkbox"/> No <input type="checkbox"/> Crime Reference Number:

RISK FACTORS

Please tick all risk factors that apply – Where there are 4 or more ticks, please complete a DASH Risk Assessment with the Victim

<input type="checkbox"/> Separation	<input type="checkbox"/> Controlling behavior	<input type="checkbox"/> Perpetrator is misusing drugs
<input type="checkbox"/> Client is very frightened	<input type="checkbox"/> Threats to kill client or others	<input type="checkbox"/> Perpetrator is misusing alcohol
<input type="checkbox"/> Assaults have become more dangerous	<input type="checkbox"/> Child contact/residency proceedings	<input type="checkbox"/> Perpetrator has breached court orders
<input type="checkbox"/> Frequency of incidents has increased	<input type="checkbox"/> Pregnancy/birth in the last 12 months	<input type="checkbox"/> 'Cultural' issues (language, 'honour' etc.)
<input type="checkbox"/> Isolation	<input type="checkbox"/> Risk of harm to children	<input type="checkbox"/> None of these
<input type="checkbox"/> Sexual violence	<input type="checkbox"/> Attempts to choke or suffocate	

HELP SOUGHT BY CLIENT

Please indicate what help the client is seeking at this point – please tick all that apply

<input type="checkbox"/> General advice, information and support	<input type="checkbox"/> Housing transfer/move	<input type="checkbox"/> Legal – divorce/separation
<input type="checkbox"/> Police action	<input type="checkbox"/> Housing advice and information	<input type="checkbox"/> Legal – family law (child arrangement orders)
<input type="checkbox"/> Health treatment/advice	<input type="checkbox"/> Housing emergency housing/refuge	<input type="checkbox"/> Legal – injunction
<input type="checkbox"/> Counselling	<input type="checkbox"/> Housing repairs/security	<input type="checkbox"/> Legal – immigration/asylum
<input type="checkbox"/> Financial/benefits	<input type="checkbox"/> Children – support/counselling	<input type="checkbox"/> Other (please specify)
<input type="checkbox"/> Sexual violence	<input type="checkbox"/> Children – child protection	
<input type="checkbox"/> Help for perpetrator	<input type="checkbox"/> Help for drugs/alcohol misuse	

LEGAL PROTECTION CURRENTLY IN PLACE

Are there any court orders currently in place? Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes, please give details:	Date Issued	Date expires	Power of arrest attached? Yes <input type="checkbox"/> No <input type="checkbox"/>

PREVIOUS AGENCY INVOLVEMENT

Has the client reported the abuse to any other agencies? Please tick all that apply

<input type="checkbox"/> Police	<input type="checkbox"/> Specialist VAWG service (please specify)	<input type="checkbox"/> LBTH DV Team (Dutyline)
<input type="checkbox"/> Children's Social Care	<input type="checkbox"/> GP	<input type="checkbox"/> School (please specify)
<input type="checkbox"/> Adult Social Care	<input type="checkbox"/> Maternity Services	
<input type="checkbox"/> Housing Options	<input type="checkbox"/> Health Visitor	
<input type="checkbox"/> Victim Support	<input type="checkbox"/> Children's Centre	
<input type="checkbox"/> One Stop Shop	<input type="checkbox"/> Solicitor	
<input type="checkbox"/> Housing Options DV Drop-in	<input type="checkbox"/> Mental Health Service	
<input type="checkbox"/> Barkantine Medical Centre DV Drop-in	<input type="checkbox"/> Other (please specify)	

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ADVICE GIVEN & ACTION TAKEN

Please briefly describe what action you have taken/are taking in relation to this case:

Have you closed the case? Yes No

REFERRALS TO OTHER AGENCIES

Referral made to: Sanctuary Project MARAC DV One Stop Shop IDVA service Floating Support Service Violent Crime Service

Please give details of all agencies you are referring the client on to

Date Referred:

Has the DV1 form been sent to the LBTH DV Team for monitoring? Yes No

CLIENT CONSENT

Data Protection requirements are that the client’s permission has been given before passing personal information to another agency. If the client cannot sign the form in person to confirm this, you may sign on their behalf. Signing the form on behalf of the client confirms that their permission has been given.

I.....(print client’s name) have checked the information on this form and agree that it is accurate. I agree to my details being passed to the agencies stated above, and that the agencies identified on this form may share information pertaining to my case for the purpose of providing me with services and protection. I consent to this information being recorded in a confidential database located with the LBTH Domestic Violence Team.

Client Signature.....

Date:

OR tick here if consent given by phone

Date:

Referrer Signature:.....

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