**Domestic Abuse Perpetrator Intervention Professionals’ Referral Form**

Please return the form to [CITC@cranstoun.org.uk](mailto:CITC@cranstoun.org.uk)

If you are using the CJSM secure mechanism you are not required to password protect the document. If you are using non secure email please password protect your document and notify us of the password in a separate email. Please do not include the password in the same email as the document you are sending.

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| **Referrer Details** | | | | | | | |
| Name of referrer | |  | | | Date of referral | |  |
| Position | |  | | | | | |
| Name of organisation | |  | | | | | |
| Contact details Telephone/email | |  | | | | | |
| **CONSENT**  **Please confirm that consent has been given by the victim and/or perpetrator for this referral and that they are happy for you to share their information with partners on a need-to-know basis.** | | **VICTIM**  Yes No  **PERPETRATOR**  Yes No | | | | | |
| **Victim Details** | | | | | | | |
| First name |  | | date of birth | | |  | |
| Surname |  | | Age | | |  | |
| Address |  | | | | | | |
| Telephone number(s) |  | | Email |  | | | |
| Safe to call, text, leave voicemail (please give details) |  | | | | | | |
| Pregnant | Yes  No  Estimated date of delivery (EDD): | | | | | | |
| Ethnicity |  | | | | | | |
| Disability | Yes  No  Details: | | | | | | |
| Sexual orientation |  | | | | | | |
| Gender identity |  | | | | | | |
| Substance misuse | Yes  No  Details: | | | | | | |
| Mental health issues | Yes  No  Details: | | | | | | |
| Is the victim a repeat victim? | Yes  No  Details: | | | | | | |

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| **Perpetrator details** | | | |
| First name |  | Date of birth |  |
| Surname |  | Age |  |
| Address |  | | |
| Telephone number(s) |  | Email |  |
| Ethnicity |  | | |
| Disability |  | | |
| Sexual orientation |  | | |
| Gender identity |  | | |
| Substance misuse | Yes  No  Details: | | |
| Mental health issues | Yes  No  Details: | | |
| Any current court involvement? | Yes  No  Details: | | |

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| **Other agencies involved** | **Details** |
| Health Visitor | Yes  No  Details: |
| Criminal Justice/Probation | Yes  No  Details: |
| Mental Health Services | Yes  No  Details: |
| Other health services | Yes  No  Details: |
| Other |  |

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| **Child/ren Details** | | | | | | | | | | | |
| **Name** | **M/F** | **DOB** | | **Age** | **Ethnicity** | **Relationship to child** | | | **Name of school or college** | | |
| **Victim** | **Perpetrator** | |
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| **If living elsewhere, please give details:** | | | | | | | | | | | |
| **Child** | | | **Name of carer** | | | **Relationship** | **Address** | | | | |
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| **Current Children’s Services involvement** | | | | | | Child in Need | | Yes  No | | Date started |  |
| Local Authority |  | |  | | | Child Protection | | Yes  No | | Date started |  |
| Social Worker |  | |  | | | Any other legal orders in place | | | |  | |

| **Reason for referral, case history and any other relevant information:** |
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***Please ensure all referral forms sent via non-secure email method are password protected. Passwords should be sent to us in a separate email to meet safeguarding protocol and ensure data breeches are not made. Please note this is a controlled document. Any printed copies of this document are not controlled. As a controlled document, this document should not be saved onto local or network drives but should always be accessed from the website. Thank you.***