

Service Against Sexual Violence Referral Form

| REFERRING AGENCY DETAILS | | | | | | |
|---|--------------------------|-----------------------|-----|-----|----|--|
| Name of referring agency: | | | | | | |
| Name of referring worker: | | | | | | |
| Phone: | Email: | | | | | |
| CLIENT DETAILS | | | | | | |
| Client name: | DOB: | | | | | |
| Address: | | | | | | |
| Email: | | Contact number: | | | | |
| Email preferred: Yes | No | Safe to call as DVAC: | | Yes | No | |
| Best contact time: | Safe to leave a message: | | Yes | No | | |
| Identifies as: Aboriginal Torres Strait Islander | | CALD client: | | Yes | No | |
| Other: Yes No | Interpreter needed: | | Yes | No | | |
| Please specify: | Primary language: | | | | | |
| Disability: Yes No Type: | | | | | | |
| EMERGENCY CONTACT | | | | | | |
| Does the client have a safe person we could contact? Yes No | | | | | | |
| Name: | Relationship: | | | | | |
| Contact details: | | | | | | |
| REASON FOR REFERRAL (e.g., why is the client seeking support now, recent trigger/s, therapeutic goals): | | | | | | |

dvac.org.au





| SEXUAL VIOLENCE INFORMATION | | | | | | | | |
|---|---------------|----------------|-------------|--------|------------------|-----------|-------|---------|
| Historical sexual | assault | Childhoo | od sexual a | ssault | Rec | ent discl | osure | |
| ACUTE (LESS THAN 24 HRS TO 1 MONTH): CONTACT STATEWIDE SEXUAL ASSAULT HELPLINE 1800 010 120 | | | | | | | | |
| Alleged offende | rs name: | | (| Ongoir | ng risk of harm: | Yes | No | Unknown |
| Reported: Support required to report: | | | | | | | | |
| Police | Yes | No | N/A | | Child Safety | Yes | No | N/A |
| Youth Justice Conference (if applicable): Court: | | | | | | | | |
| Family Law Cour | rt involvemer | nt: Yes | No | N | /Α | | | |
| Victim Assist Qu | eensland (VA | Q) application | submitted | l: Ye | s No | Unk | nown | |
| | | | | | | | | |

IDENTIFIED RISKS

| ANY FURTHER INFORMATION | | |
|--|------------------------|--|
| | | |
| | | |
| | | |
| Referral discussed with client: Yes No | Date consent provided: | |
| (Please note a referral will only be accepted with clien | | |

DVAC takes seriously the rights of all clients to confidentiality and privacy of information including the right to remain anonymous if they choose. We recognise our duty of care to safeguard information which could jeopardize the security and safety of adults, children, or young people accessing DVAC services. DVAC is guided by standards of the AustralianPrivacy Principles on the collection, storage, disclosure and use of personal information about individuals.

Please download this form and fill it in, then email manually or click on the buttons to submit via email.

| Ipswich | intakeipswich@dvac.org.au | Subject line: SASV Referral | Submit buttons: |
|-----------|---------------------------|-----------------------------|-----------------|
| Toowoomba | intaketwba@dvac.org.au | Subject line: SASV Referral | |