

Request for ISVA Support Referrals to be emailed directly to

|  |
| --- |
| Refer Details: |
| Referrer role: |
| Referrer contact details:  Phone:  Email: |

Date completed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Sail Received:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Referral**: Self / Other

If other state:

|  |  |
| --- | --- |
| Reason for Referral:  Offence\* |  |

**SAIL does not work with perpetrators of sexual violence.**

\*Please put in type of Offence i.e.; Non recent (over 12 months) Recent (with the last 12 months) Rape, Sexual Violence, Grooming, Incest, sexual harassment, pornography etc.

**Personal Information:**

**Client consent to referral obtained:** YES / NO

Client number (To be completed by SAIL):\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| Name: |  |
| DOB: |  |
| Address: |  |
| Postcode: |  |
| Telephone:  Mobile: |  |
| Safe to write to client | Yes / No |
| Safe to call | Yes / No |
| Best times to contact: |  |
| Gender: |  |
| Ethnicity: |  |
| Sexuality: |  |
| Marital Status: |  |
| Children:  If Yes do they live with client? | Yes / No |
| Employment status: |  |
| Religion / Belief: |  |
| Immigration status: |  |
| In receipt Benefits: |  |
| Housing | Owned / Private / Social |

Any Immediate safety / risk concerns for client? ………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………

Any Safety of risk issues ISVA staff should be aware of?

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**Disabilities / Needs:**

|  |  |
| --- | --- |
| Physical  Disability: |  |
| Learning needs or disability: |  |
| Communication needs: |  |

**Health:**

|  |  |
| --- | --- |
| GP Name & Address:  Tel: |  |
| Diagnosed / undiagnosed Health (physical / mental) Conditions: |  |
| Medication Prescribed: |  |
| Pregnancy (state if result of SV/SA) Maternity: |  |
| Substance Misuse issues  Current / historic (brief info) |  |
| Treatment: | In Treatment / Not in Treatment |

**Any Additional Support Service Involved:**

|  |  |
| --- | --- |
| Social Care:  Level if CYPD: | Adults Children’s |

|  |  |  |
| --- | --- | --- |
| Organisation / Role | Name of Worker | Address / Contact Number |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**ISVA info:**

|  |  |
| --- | --- |
| Have they attended SARC? | Yes / No |
| Any sexual health support needs? (Brief details) | Yes / No  …………………………………………………  ………………………………………………...  ………………………………………………… |
| Have they reported to Police? (Dates if known)  ***\*Crime Reference Number, (Occurrence number )***  ***Police officer / (Badge Number) involved required*** | Yes / No |
| Has a charge been given? | Yes / No |
| Trial / Court Dates if known: |  |
| Civil / Criminal: |  |

**Any other relevant information: Please DO NOT INCLUDE INFORMATION THAT HAS BEEN GIVEN IN EVIDENCE (In terms of detail pertaining to a report as this can result in reallocation of ISVA support due to coaching)**

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**Date completed/ emailed to SAIL:**

**Staff Details Reviewing:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Outcome:** ISVA Support Offered / Not Offered

**Date of 1st Appointment:**