**The Ferns Child/Young Person ISVA Referral Form**

**PLEASE COMPLETE EACH SECTION FULLY**

Consent must be obtained from the client and parent/carer before a referral can be sent to The Ferns

Has consent been given by victim **Yes**

**No**  please contact The Ferns 01473 668974 before completing this referral

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| **Name of referrer:**  **Contact details of referrer:** |
| **Reason for referring?** |
| **Date disclosure was made to referrer?** |
| **Has the client previously attended or been referred to The Ferns? YES NO** |
| **Investigation/Case number:** |
| **Brief details of offence:** |

**Clients Details**

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| --- | --- | --- | --- |
| **First name:**  **Title:** | **Surname:** | | **Previous Surnames:** |
| **DOB: Age:** | **Partnership Status:**  Married **/** Single **/** Cohabiting **/** Separated **/** Divorced **/** Widowed **/**  In a relationship with perp | | **Gender:** |
| **Sexual Orientation:**  Bisexual **/** Gay Man **/** Gay Women  Heterosexual **/** Other: | | **Economic Status:**  Fulltime **/** Part-time **/** Unemployed  Jobseekers **/** Education **/** Retired **/** Sickness **/** Disability | |
| **Nationality:** | | **First Language:**  **Is an interpreter required/used:** Yes No | |
| **Address:**  **Postcode:**  **Is it safe to write to this address?** Yes No | | **Landline:**  **Mobile: Seized** Yes No  **OK to call** Yes No  **OK to text** Yes No  **OK to leave a message** Yes No | |
| **Email address:** | | **Preferred method of contact:** | |
| **Preferred person to contact:** Self Parent Carer Social Worker Support Worker | | | |
| **In case of emergency details:**  **Name:**  **Address:**  **Relationship:**  **Landline:**  **Mobile:** | | **GP details:**  **Name:**  **Address:**  **Landline:** | |
| **Parent/Carer1 Name:**  **Parent/Carer1 Landline/Mobile:**  **Ok to leave message?** Yes No  **Ok to text?** Yes No  **Ok to say The Ferns?** Yes No | | **Parent/Carer2 Name:**  **Parent/Carer2 Landline/Mobile:**  **Ok to leave message?** Yes No  **Ok to text?** Yes No  **Ok to say The Ferns?** Yes No | |
| **Parental responsibility held?** Yes No | | **Parental responsibility held?** Yes No | |
| **Social Worker:**  **Location Team:**  **Contact number:** | | **Child/Young Persons school/college:** | |
| **Details of other children regularly in the property:** | | | |
| **NAME** | **DATE OF BIRTH** | | **RELATIONSHIP** |
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| **Any disabilities or mobility issues:** | **Vulnerabilities:** (Learning/mental health/sex worker/alcohol/drugs/self-harm) | | **Medical priorities:**  (Pregnant/medication) |

**Ethnicity**

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| --- | --- |
| **Asian or British Asian (A)**  Indian A1  Pakistani A2  Bangladeshi A3  Any other Asian background A9  **Black or Black British (B)**  Caribbean B1  African B2  Any other Black background B9  **Chinese or Other Ethnic Group (O)**  Chinese O1  Any other ethnic group O9 | **Mixed (M)**  White and Black Caribbean M1  White and Black African M2  White and Asian M3  Any other mixed background M9  **White (W)**  British W1  Irish W2  Any other White background W9  Not Known  Not Stated |

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| **Do you have any issues with reading or writing:**  Yes No | **Is this domestic related:** Yes No  **Has a DASH been completed:** Yes No  **If Yes what score:** | | |
| **Is this a Hate Crime:**  Yes No | **Has a Safeguarding Referral been submitted:**  Yes No | | |
| **Another other relevant information:** | | | |
| **Name of Offender:**  **Age/DOB:**  **Offenders ethnicity:**  **Relationship to you:**  **Location of offence:** | | | |
| **Would you be willing for The Ferns to give anonymous intelligence to police?(If no police involvement)** | | YES | NO |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Are you working with any other agencies?** | **YES (details below)** | **NO** | | |
| **NAME** | **AGENCY** | **CONTACT DETAILS** | | |
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| **Are you happy for The Ferns to discuss your case with the relevant GUM clinic?** | | | YES | NO |
| **In order for us to fully support you we need to talk to any other professional that is working with you. Are you happy for us to contact them?** | | | YES | NO |

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| **Any relevant information and details the ISVA needs to know:** |

**Client’s signature:**…………………………………………………………………………………………

**Parent/Carer/Appropriate Adult’s signature**:……………………………………………………………….

Please return this completed form to [contact@theferns-suffolk.org.uk](mailto:contact@theferns-suffolk.org.uk). If you are police please use the SARC email from the internal address list. Your application with be assessed to ensure it meets The Ferns criteria but if it fails, we will return it to you.

Providing the triage is successful your referral will be processed and allocated to the appropriate ISVA. Please be aware that due to ISVA case loads there may be a waiting list in operation. Please therefore continue to support your client until contact is made by the ISVA. Upon receipt of this referral form, The Ferns will contact you to advise of the current waiting time