POTTON GROUP

WHERE CHILDREN AND FAMILIES MATTER

Potton Kare Services Independent Domestic Abuse Advisor Referral

Please complete all sections of this form

Please provide details of all adults being referred							
Local Authority ID Number	Forename	Surname	DOB	Gender/Identifies as (pronoun)	Ethnicity	Religion	Language

Home Address Including Postcode

Please provide details of any children relevant to the intervention					
Relationship	Name	Contact Number	Gender/Identifies as (pronoun)	Ethnicity	Language

Communication: Any Special Communication Needs?	
Yes/No (delete as appropriate)	**If yes please provide details:**

Referral Details				
Name of Referrer	Role of Referrer	Contact Number	Email	Name of Authorising Manager

History of Case and Current Situation/Reason for intervention Being Required

Intervention Details				
Type of intervention Required (eg Freedom Programme, Perpetrator Programme etc)	**Preferred Intervention start date**	**Preferred Intervention completion date**	**Name of person receiving the intervention?**	**Are there any children that need to be included in the intervention? If Yes, please provide details of the level of inclusion you would like them to receive.**

Additional Information
Please give details of any additional information that the Practitioner should be aware of (For example, dates for mid-way meetings)

Risk Assessment – Adult/s			
	Y/N	**If YES, please provide details** ***e.g. whether this is current or historical***	**If YES, how would you like this to be managed by the worker?**
Does any adult residing in the home have issues of alcohol, solvent, or other substance misuse?			
Has any adult residing in the home ever displayed sexualised behaviour towards children or adults?			
Has any adult residing in the home ever displayed physical threats or violence towards a professional?			
Has any adult residing in the home ever displayed verbal or racist abuse towards a professional?			
Is any adult residing in the home engaging in, or have a history of, criminal activity?			
Are there any other risks that may be posed by any adult residing in the home that the Practitioner needs to be aware of?			

Please provide details of where invoices for this service should be sent (Please note, referral will not be accepted if this section is not completed)	
Name	
Role	
Department	
Email	
Telephone number	

Authorisation	
Signed (referrer)	
Date	
Signed (Authorizing Manager)	
Date	