**Jewish Women’s Aid Referral Form**

**Please reply to:** **clientsupport@jwa.org.uk**

**Referral Date:**

**Please ensure the client meets the criteria for accessing our Domestic Abuse / Young Women’s Advocacy services including practical support and counselling:**

* Identifies as Jewish or converting to Judaism
* Female / trans\* female
* Abuse is familial, partner or ex-partner abuse

**Please ensure the client meets the criteria for accessing our Sexual Violence ISVA service:**

* Identifies as Jewish or converting to Judaism
* Female / trans\* female
* Would like to explore criminal justice options with no pressure to proceed

**Please ensure the client meets the criteria for accessing our Sexual Violence Counselling service:**

* Identifies as Jewish or converting to Judaism
* Female / trans\* female
* Would like to access counselling

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| **Please TICK the box below to confirm the client has given permission to refer to JWA**  |
| YES |
| **Please indicate which JWA service(s) you’d like to refer to (please tick):** |
| Domestic Abuse Service /Young Women’s Advocacy Sexual Violence ISVA Service Sexual Violence Counselling Service  | 🞎🞎🞎 |
| **Please enter your name and contact details:** |
| Referrer’s nameOrganisation nameContact numberContact email |

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| **Please indicate your agency type:**  |
| Professional referral Health Another DV service Helpline Another SU service Probation Adult social services Police Children’s services Voluntary / community group Drugs / alcohol Education Other  | 🞎🞎🞎🞎🞎🞎🞎🞎🞎🞎🞎🞎🞎🞎 |

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| **How did you find out about our service? (Please tick)** |

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| Flyer / poster Made a referral before TV / radio NDVH Online Another service Word of mouth Other  | 🞎🞎🞎🞎🞎🞎🞎🞎🞎 |

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| **Please enter the details of the person you’re referring:** |
| First nameLast nameOther / previous namesDate of birth |

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| **Information about the person being referred to Jewish Women’s Aid** |
|  | **Safe to contact** |  |
| Telephone |  | Yes No  | 🞎🞎 |
| Email |  | Yes No  | 🞎🞎 |
| Address |  | Yes No  | 🞎🞎 |
| Borough where she currently resides |  |
| Is the client living with the perpetrator/s? |  |
| Is the client currently in refuge accommodation? |  |
| **If the client is under 18, has parent / carer consent been sought for the referral?** |
| YesNo, not soughtNo, not safe to seek | 🞎🞎🞎 |
| Has the client used this service before? | Yes No Not sure  | 🞎🞎🞎 |
| Is the client currently pregnant? | Yes No Not sure If yes, due date: | 🞎🞎🞎 |
| Primary Language |  |  |
| Other languages spoken |  |  |
| Clients gender | Female Don’t Know  | 🞎🞎 |
| Is the client’s gender different to the gender they were assigned at birth? (Are they transgender?) | Yes No Don’t know  | 🞎🞎🞎 |

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| **Briefly outline the reason you’re making a referral to JWA today, and how you feel the client could benefit from our support.** |
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| **Client referred for support around: (Please tick all that apply)** |
| Coercive control Sexual exploitation Physical abuse Trafficking Sexual abuse Rape Sexual assault FGM Emotional / psychological abuse HBV Financial abuse Forced marriage Harassment / stalking Other  | 🞎🞎🞎🞎🞎🞎🞎🞎🞎🞎🞎🞎🞎🞎🞎 |
| Does the client have any children? If so, how many? |
| **Please provide children’s names and DOB if known:** |
| Name | DOB |  |
| Name | DOB |  |
| Name  | DOB |  |
| Name | DOB |  |

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| **What is the client’s ethnicity? (Please tick)** |
| White British White Irish White Gypsy or Irish Traveller Any other white background Asian British Asian Indian Asain Pakistani Asian Bangladeshi Any other Asian background  | 🞎🞎🞎🞎🞎🞎🞎🞎🞎🞎 | White and Black Caribbean White and Black African White and Asian Any other mixed/multiple background Black British Black African Black Caribbean Any other Black background Chinese Arab Any other ethnic group Don’t know  | 🞎🞎🞎🞎🞎🞎🞎🞎🞎🞎🞎🞎🞎🞎  |
| **What is the client’s level of religious observance? (Please tick)** |
| Chasidish Charedi Modern Orthodox Traditional Masorti Reform Liberal Secular Cultural Other  | 🞏🞏🞏🞏🞏🞏🞏🞏🞏🞏 |  |
| **What is their nationality?** |
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| **What is their relationship status? (Please tick)** |
| Civil Partnership Married Divorced Separated Cohabiting but not married In a relationship (not cohabiting) Widowed Single Don’t know  | 🞏🞏🞏🞏🞏🞏🞏🞏🞏🞏 |
| **What is their sexual orientation? (Please tick)** |
| Heterosexual Gay woman/lesbian Bisexual Other……. Don’t know  | 🞏🞏🞏🞏🞏 |
| **Does the client have any disability? (Please tick)** |
| None Yes:Physical Learning Deaf/hard of hearing Blind/visually impaired Mental health Other  | 🞏🞏🞏🞏🞏🞏🞏🞏 |
| ***Notes:*** |
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| **Please tell us more about any support needs the client may have:** |
|  |  |  | Comments: |  |
| Recourse to public funds | Yes No Not sure  | 🞏🞏🞏 |  |  |
| Support needs around alcohol | Yes No Not sure  | 🞏🞏🞏 |  |  |
| Support needs around drugs | Yes No Not sure  | 🞏🞏🞏 |  |  |
| Support needs around mental health | Yes No Not sure  | 🞏🞏🞏 |  |  |
| BSL/interpreter required | Yes No Not sure  | 🞏🞏🞏 |  |  |
| Does the client have any accessibility requirements | Yes No Not sure  | 🞏🞏🞏 |  |  |
| Does the client have any previous convictions | Yes No Not sure  | 🞏🞏🞏 |  |  |
| ***If you have any other important/useful information about this woman’s support needs, please provide additional details below:*** |
| Are there any known risks to working with this client? |
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| Please provide GP’s details |
| NameAddress |
| Telephone number |
| **Please provide information for client’s next of kin/emergency contact** |
| NameAddress |
| Telephone number(s)Safe contact notes: |