



# Family Violence Outreach Referral Form QLD

Mackay, Isaac Region, Sunshine Coast & Gold Coast

*If you or anyone else is in immediate danger, please contact emergency services on 000. For a 24/7 crisis response please contact DVCONNECT on 1800 811 811.*

*TSA Family Violence Outreach Services support consenting adult victim-survivors and their children experiencing, or who have experienced, family and domestic violence. Clients are provided with specialised case-management including risk assessments, safety planning, referral to appropriate services, advocacy, and support.*

Please e-mail the completed form to:

- Mackay and Isaac Region: [msu@salvationarmy.org.au](mailto:msu@salvationarmy.org.au)
- Sunshine Coast and Gold Coast: [scdfv@salvationarmy.org.au](mailto:scdfv@salvationarmy.org.au)

<b>Date of referral:</b>			
<b>ADULT VICTIM-SURVIVOR DETAILS</b>			
<b>Name</b>			
<b>Date of Birth</b>		<b>Age</b>	
<b>Address</b>			
<b>Is address known to the Person Using Violence?</b>			
<b>Contact Number</b>		<b>Is it safe to call / text?</b>	Please select
<b>Safe times or methods of contact</b>			
<b>Gender</b>			
<b>Cultural Identity</b>			
<b>Residency Status</b>			
<b>Visa Status and Year of Arrival (where applicable)</b>			



<b>Interpreter Required</b>	
<b>Living with a Disability</b>	
<b>Details of Disability/Support Needs</b>	
<b>Pregnant</b>	

<b>CHILDREN (if applicable)</b>		
<b>Child One</b>	<b>Name</b>	
	<b>Date of Birth</b>	
	<b>Gender</b>	
	<b>Is the child in the care of the victim-survivor?</b>	
	<b>Relationship to the Person Using Violence</b>	
<b>Child Two</b>	<b>Name</b>	
	<b>DOB</b>	
	<b>Gender</b>	
	<b>Is the child in the care of the victim-survivor?</b>	
	<b>Relationship to the Person Using Violence</b>	
<b>Child Three</b>	<b>Name</b>	



CHILDREN (if applicable)		
	DOB	
	Gender	
	Is the child in the care of the victim-survivor?	
	Relationship to the Person Using Violence	
Child Four	Name	
	DOB	
	Gender	
	Is the child in the care of the victim-survivor?	
	Relationship to the Person Using Violence	
Child Five	Name	
	DOB	
	Gender	
	Is the child in the care of the victim-survivor?	
	Relationship to the Person Using Violence	



Person Using Violence			
<b>Name</b>			
<b>DOB</b>			
<b>Address</b>			
<b>Gender</b>			
<b>Cultural identity</b>			
<b>Relationship</b> (i.e. spousal, family)			
<b>Is there an DVO in place?</b>	Please select	<b>If no, has there previously been one in place?</b>	Please select
<b>Breaches of the DVO</b>	Please select		
<b>Please provide any additional information relating to the DVO</b>			
<b>Does the Person Using Violence use alcohol or other drugs?</b>	Please select		
<b>Please provide any additional information relating to the Person Using Violence</b>			

REFERRER/SELF-REFERRAL	
<b>Name</b>	
<b>Agency</b> (N/A if self referral)	
<b>Phone number</b>	
<b>E-mail address</b>	
<b>Nature of involvement</b> (N/A if self referral)	
<b>Self referral</b>	



<b>REFERRAL</b>
<p><b>Reason for Referral</b>  <i>(Please summarise the behaviours by the Person Using Violence and include the most recent behaviours)</i></p>
<p><b>Victim-Survivor Assessment of Risk</b>  <i>(What does the victim-survivor think the Person Using Violence might do and to whom? Level of fear?)</i></p>
<p><b>Additional information</b>  <i>(Please provide any additional relevant information i.e. mental health diagnosis, AOD use, staff safety considerations, child safety involvement, family law court information etc.)</i></p>

<b>SUPPORT SERVICES</b>
<p><i>Please indicate the type(s) of support the victim-survivor may require</i></p>
<p><input type="checkbox"/> Risk assessments and safety planning</p>



<input type="checkbox"/>	Advice and information
<input type="checkbox"/>	Advocacy with systems and services
<input type="checkbox"/>	Emotional support and/or counselling
<input type="checkbox"/>	Legal support (legal information, referral to legal service, court support)
<input type="checkbox"/>	Support accessing financial grants / payments
<input type="checkbox"/>	Warm referrals to other services
<input type="checkbox"/>	Group programs
<input type="checkbox"/>	Support sustaining housing ( <i>Mackay and Isaac Region only</i> )
<input type="checkbox"/>	Other <i>Please specify</i>

**If a Risk Assessment and/or Safety Plan have been completed with the victim-survivor, please attach this in addition to the referral form. Please also attach a copy of the Domestic Violence Order, where available)**

FOR OFFICE USE ONLY	
<b>Date referral received</b>	
<b>Is the service suitable for the victim-survivor?</b>	Please select
<b>Has the referrer been updated about the outcome?</b>	Please select
<i>If service is not suitable</i>	
<b>Why was the service not suitable?</b>	Please select
<b>Have other options for service referral been explored with / on behalf of the victim-survivor?</b>	Please select

**Document Information**

<b>Document Name</b>	Family Violence Outreach Referral Form QLD
<b>Theme</b>	Mission Delivery
<b>Category</b>	Social Program
<b>Owner</b>	Social Mission Family Violence Stream
<b>Approving Authority</b>	General Manager Family Violence
<b>Review Date</b>	September 2024
<b>Next Review Date</b>	September 2025

**Document History**

Version	Date Approved	Summary of Changes
1-0	September 2024	Inaugural version