

**MH IDVA REFERRAL FORM**



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| **Email form to:** | [**MHIDVA@niaendingviolence.org.uk**](mailto:MHIDVA@niaendingviolence.org.uk) |
| **Office Phone:** | **020 7683 1270 Mon – Fri 10.00am – 5.30pm** |
| **MH IDVAs details** | **Saskia Bassey-Billinge:** [sbassey-billinge@niaendingviolence.org.uk](mailto:sbassey-billinge@niaendingviolence.org.uk)  Mob: 07816 087447  **Eirini Vounatsou**: [evounatsou@niaendingviolence.org.uk](mailto:evounatsou@niaendingviolence.org.uk)  Mob: 07816 087451 |

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| Date of Referral |  | |
| **Referring agency / professional’s name** |  | |
| Professional telephone / email |  | |
| **Service user/ patient’s Name** |  | |
| Did she consent to being referred? |  | |
| Address |  | |
| Date of Birth |  | |
| Ethnic background / nationality |  | |
| Sexual orientation |  | |
| Religion |  | |
| Employment status |  | |
| Language/Interpreter required? |  | |
| Safe telephone number for the client (or another means by which client can be contacted)? |  | |
| Is it safe to leave a message/text this number? | **YES/NO** | |
| Any safe /unsafe times to contact? | **YES/NO** | Details |
| Are there ANY children under 18 in the household? | **YES/NO** | If so, how many? Who? |
| Has the client a MH diagnosis? | **YES/NO** | 1. **IF YES**,which**?** 2. Which support is the patient receiving from the MHTeam? 3. Which team/ leading professional is involved? Details of involvement. 4. Is the person taking medication? If so, which?   **IF NOT,** what are the symptoms? |
| Has the client any substance use issues? | **Yes/ No** | **Details:** |
| Any disabilities? Physical health support needs? | **Yes /No** | **Details:** |
| Has the client any suicidal ideation/ past attempts on her life/ self -harm? | **Yes/ No** | **Details:** |
| Other professionals involved? E.g. Social Care, Police | **YES/NO** | **Details of other professionals involved:** |
| **Reasons for referral:**  **Details of domestic abuse /incident disclosure.** | | |
| **Details of perpetrator of abuse:** | **Name & DOB:** | |
| Relationship |  | |
| Do they live together? |  | |
| Actions taken following disclosure. |  | |
| Safeguarding completed? | **YES/NO** | **YES:** Date / Outcome  **NO:** Reasons |

Please send completed referral to: [MHIDVA@niaendingviolence.org.uk](mailto:MHIDVA@niaendingviolence.org.uk)