**MY TIME SELF REFERRAL FORM**

**Wolverhampton Community DVPP**

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| **PLEASE SEND COMPLETED REFERRALS TO:** [**DVPPMytime@richmondfellowship.org.uk**](mailto:DVPPMytime@richmondfellowship.org.uk) |

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| **CLIENT INFORMATION (male):** | |  | | |
| Title: | | D.O.B: | | |
| First name: | |  | | |
| Surname: | |  | | |
| Current Address:  Incl Postcode | |  | | |
| How long have you lived at the above  address: | |  | | |
|  | | Details: | | Safe to contact? |
| Contact number: |  | | |  |
| Contact email: Safe to contact: |  | | |  |
| Can we leave a voicemail? |  | | |  |
| Can we text client? |  | | |  |
| Can we write to client at the above address? |  | | |  |
| Please specify any requirements in relation  To contacting client (such as best time): |  | | | |
| Ethnicity: | Religion: | | | |
| Language needs: | Y / N | | Details: | |
| Accessibility requirements: | Y / N | | Details: | |

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| **CHILDREN:**  *Please provide all details of child/ren below use a separate sheet if required* | | | | |
| **Name:** | **D.O.B** | **Gender:** | **Living with**  **client?** | **If no provide address:** |
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| **Reason for referral including recent concerns of abusive behaviour and any pending court cases:** | | |
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| Has there been any recent attempts to kill including strangulation? | Y / N | Details: |

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| **Please provide details relevant from the following to help outline the needs of the family:** | | |
| Is the family subject to a CP plan? | Y / N | |
| Is the family subject to a CIN? | Y / N | |
| How long has the family been subject to CP / CIN? |  | |
| SECTION 47 | |  |
| COURT ASSESSMENT | |  |
| CHILD PROTECTION MINUTES / REPORTS | |  |
| CORE ASSESSMENT | |  |
| CAF ASSESSMENT / FORMS | |  |

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| **Please list below any details of forthcoming meetings / reviews / conferences / court dates:** | | |  |
| **Meeting / review /**  **Conference / court date:** | **Date:** | **Venue:** | **Professional to contact**  **in relation to this:** |
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| **Client additional needs / risks** | | | | |
| Mental Health | Substance Misuse | | Alcohol abuse | |
| Offending | Other | | | |
| Is this client a risk to other professionals/ (incl details): |  | | | |
| If there are additional needs please include details of any professionals involved with client: | Name of  Worker: | Company: | | Contact details: |
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| **Client employment status:** |
| Please circle where applicable:  Carer Full Time work (16hrs +) Full time student Job seeker  Retired Part Time work (-16 hours) Voluntary work Government training scheme  Apprenticeship Not seeking employment Part time student |

**AS PART OF THIS SERVICE WE ARE REQUIRED TO OBTAIN INFORMATION OF YOUR CURRENT PARTNER AND/OR YOUR EX PARTNER, OF WHOM THE ABUSIVE RELATIONSHIP WAS / IS WITH.**

**PLEASE PROVIDE ACCURATE DETAILS BELOW.**

**IF YOU DO NOT HAVE ACCESS TO THIS INFORMATION PLEASE CLEARLY STIPULATE BELOW AND WE MAY CONTACT YOU FOR FURTHER INFORMATION TO DISCUSS.**

*The partner / ex partner of the perpetrator will be contacted and offered a service via womens support services and be subject to regular update calls where consent is received to do so, in order to allow us to monitor risks and additional support needs.*

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| **FEMALE PARTNER / EX PARTNER CLIENT INFORMATION:** | |  | | |
| Title: | | D.O.B: | | |
| First name: | |  | | |
| Surname: | |  | | |
| Current Address:  Incl Postcode | |  | | |
| How long have you lived at the above  address: | |  | | |
|  | | Details: | | Safe to contact? |
| Contact number: |  | | |  |
| Can we write to client at the above address? |  | | |  |
| Please specify any requirements in relation  To contacting client (such as best time): |  | | | |
| Ethnicity: | Religion: | | | |
| Language needs: | Y / N | | Details: | |
| Do the children live in the above address | Y / N | |  | |
| Does the you live at the above address? | Y / N | |  | |
| Is this a current or ex partner? |  | |  | |
| Is this person aware their details have been provided as a part of this referral? | Y / N | |  | |

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| **CONSENT TO STORE AND DISCLOSE INFORMATION ABOUT YOU**  **Male receiving DVPP**  ***PLEASE BE AWARE THAT WITHOUT YOUR CONSENT TO THE BELOW WE WILL BE UNABLE TO PROCESS THIS REFERRAL AND YOU WILL BE ILLEGIBLE FOR OUR SERVICE***  I\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ agree to take part in the My Time DVP 30 week Programme and I understand that my case is confidential however it will be necessary to discuss my details with other partners / agencies involved for the benefit of information sharing.  I understand that there are parallel services for my family and discussions will take place with those involved. I agree not to interfere with this contact and understand a copy of my referral will be shared with female services.  I am also aware that the programme will be evaluated by an external university and that my case will form a part of this.  In the instance that there may be information missing from this referral I am aware that the organisation may request background information from the police in relation to a history of offending.   * From the time you apply to our service to 6 years after you have finished receiving a service from My Time division of Richmond Fellowship we will store some information about you. (It is a legal requirement we keep your records for this length of time). * What information will we keep?   Basic information including D.O.B, Contact details, next of kin, professionals working with you, some information about your background, needs and strengths. Case notes and reports in relation to the service you have received.   * Where will this information be kept?   This information will be sorted on CAPITA support system which is a secure electronic system we use to record our work with you   * Why?   In order that we understand your needs and support you in the best way possible. It is also so that we can stay in contact with you and the other people that support you. Finally, because we want to make sure that as an organisation we comply with the law and best practice in terms of equal opportunities and non-discrimination.  We need your consent to store this information:  Do you give your consent to store this information: YES / NO  Signed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Wherever possible we envisage receiving this consent prior to a referral being made to our service.**  **Where this is not the case consent will need to be obtained at the initial assessment stage with the client. Should the client refuse at this stage for us to maintain their records they will not be eligible to receive a service from My Time.** |

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