**DV Recovery Referral Form**

*DV Recovery Service offers a structured service working within a ‘step down and move forward’ approach for women who have experienced domestic abuse. We provide women with culturally competent counselling, group-based support and aftercare which with the hope of enable women to move forward and achieve their long-term recovery goals.*

*This service is based in NW London (Brent, Harrow, Hillingdon, Ealing and Hounslow) and will support any female survivor of domestic abuse in safe accommodation, including women in refuges, DA Units or self-contained units or other long or short-term accommodation. Please send referrals to* *kenderby@eachcounselling.org.uk*

**Date of referral:**

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| Self-referral (*if self-referred please fill out the information under ‘Client information’*) |

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| External referral *(if referring from external organisation please fill below)*Referring organization: Name:  Position: Email: Phone: Office:  |
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| **Client Information** |
| Title: Surname: Forename(s):DOB: |
| Is your gender different to the gender you were assigned at birth? Sexual Orientation: Relationship Status:Ethnicity: Nationality: Religion: Languages spoken:   |
| Telephone no: Mobile: |
| Email:  |
| Preferred contact?  Phone Email Text  |
| Are there any safety concerns about how you are contacted?  Yes  No ( if please state why) |
| Address:Post code:  |
| Do you consider yourself to have a disability or learning difficulty? Yes  No If yes, please specify: |

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| Where do you (woman being referred) currently live? Do you consider your current accommodation safe? Who were you experiencing abuse from? What is the current status between you and this person? *(e.g. separated, contact due to shared child custody, no contact..) Please not we cannot work with women who are still in an abusive relationship.* Do you have children, or are you currently pregnant? If so please give details. Are you working with any other services around your children (e.g. children’s social care, CAMHS, health visitor)?  |

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| How would you describe your level of need ? Low Medium High Do you consider yourself to have substance use or mental health need? * Yes No

If yes, please describe:  |

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| Any other information that you may consider important for us to know?  |

Lotus Project Team Member Receiving the Referral: …………………………………………………

Date Received:………………………….