



Referral - External service providers

Please email completed referral to intake@glws.org.au

Has client consented to this referral? Yes / No

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|-------------------|--|-----------------------|--|
| Date of Referral: | | Referring Agency: | |
| Contact person: | | Contact number/email: | |

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| Client Name: | | D.O.B: | |
| Contact Number: | | Safe to call/text: | |
| Email address: | | Safe to email: | |
| ATSI/CALD: | | | |
| Reason for referral: Details: | DV/ FV/ EVICTION/HOMELESSNESS/ PRISON/ OTHER | | |
| Immediate safety concerns: | <p><i>Is she fearful of her offender?</i></p> <p><i>Is the client wanting shelter accommodation?</i></p> <p><i>Current Accommodation?</i></p> | | |

| Child's Full Name | DOB | AGE | GENDER | CULTURAL IDENTITY /family group | IMMUNISED | EDUCATION – currently enrolled |
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DOMESTIC and FAMILY VIOLENCE

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| Offender Name: DOB: | |
| Likely to come looking for you? Yes / No | |
| Dangerous: Yes / No Access to weapons: | Details: |
| Last known location / address: | |
| Offender's identifying traits: | |
| Any police involvement? Any current AVO's for yourself or offender? | <i>(if no, encourage report to police or WDVCAS immediately, if relevant)</i> |
| Criminal history for offender? | Details: <i>(When /Charges / prison / amount of time served)</i> |

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|--|---|
| Criminal History for yourself (or anyone listed on application) | Details: <i>(When /Charges / prison / amount of time served)</i> |
| Any current or previous drug and alcohol usage for anyone listed | YES/NO What substance/s: Last usage? |
| Managed/Unmanaged mental health for anyone listed | YES/ NO Details: Medications: Management of symptoms: |
| Consent given to discuss information provided in this referral with GLWS as part of referral process | YES / NO |

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| Background or any other relevant information: | |
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| Other supports needed/ identified: | Crisis accommodation Domestic & family violence Drug & Alcohol Disability Counselling / support Education / Employment OTHER: |
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GLWS Assessment Notes: