|  |  |  |  |
| --- | --- | --- | --- |
| **Date of referral:** |  | **EDAN Staff Initials** ***(if applicable)*:** |  |
| **Client First Name:** |  | **Client Date of Birth:** |  |
| **Client Surname:** |  | **Client Age:** |  |
| **Client Alias (if applicable)** |  | **Please confirm client has consented to this referral:** | **Yes** [ ]  |
| **Client Details:** |
| **Current Client Address (including postcode):** |  |
| **Fled Address (including postcode):** |  |
| **Is client a Lincolnshire Resident:**  | **Yes** [ ]  | **No** [ ]  |
| **What is the client’s Gender?** | **Male** | [ ]  | **Non-Binary** | [ ]  | **Prefer not to say** | [ ]  |
| **Female** | [ ]  | **Prefer to self-describe** | [ ]  | **Other** | [ ]  |
| **What is the client’s biological sex (as assigned at birth?** | **Male** | [ ]  | **Female** | [ ]  | **Prefer not to say** | [ ]  |
| **Ethnicity of client:** |  |
| **Does the client require an interpreter?**  | **Yes** [ ]  | **No** [ ]  |
| *If yes, what language is required?* |  |
| **Client’s telephone contact number:**  | **Is it safe to:**  |
|  |  | **Yes** | **No** |
| **Call** | [ ]  | [ ]  |
| **Text** | [ ]  | [ ]  |
| **Leave Voicemail** | [ ]  | [ ]  |
| **Client’s Email Address:** | **Is it safe to email?**  | **Yes** [ ]  | **No** [ ]  |
|  |
| **Details of a trusted 3rd party we can safely contact should we be unable to contact the client?** | ***Consent from client to share it is EDAN Lincs calling?* Yes** [ ]  | ***If yes, please provide name, and contact details:*** |
| **Does the client have a disability including communication needs?** | ***If yes, please provide details:***  |
| **Yes** [ ]  | **No** [ ]  |  |
| **Does the client have any mental health issues?** | ***If yes, please provide details:***  |
| **Yes** [ ]  | **No** [ ]  |  |
| **Does the client have any alcohol support needs?** | ***If yes, please provide details:***  |
| **Yes** [ ]  | **No** [ ]  |  |
| **Does the client have any drug support needs?** | ***If yes, please provide details:***  |
| **Yes** [ ]  | **No** [ ]  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Has the client previously utilised safe accommodation in any location?** | ***If yes, when was this?*** | **Less than 6 months** | [ ]  |
| **Yes** [ ]  | **No** [ ]  |  | **6-12 months** | [ ]  |
|  |  |  | **Over 12 months** | [ ]  |
| **How long has the client been experiencing domestic abuse before accessing support?** |
| **Less than 6 months** [ ]  | **6-12 months** [ ]  | **Over 12 months** [ ]  |
| **Please select all the types of domestic abuse the client has been experiencing:** |
| **A pattern of controlling/ coercive behaviour** [ ]  | **Sexual violence/abuse** [ ]  |
| **Current physical abuse, violence or threatening behaviour** [ ]  | **Stalking/Harassment** [ ]  |
| **Repeated emotional/psychological abuse** [ ]  | **Financial Abuse** [ ]  |
| **Potential honour-based violence and/or female genital mutilation** [ ]  |
| **Please provide reason for professional involvement and a brief summary of information relating to domestic abuse resulting in this referral:** |
|  |
| **Perpetrator Details:** |
| **Perpetrator Name:** |  | **Perpetrator Ethnicity:** |  |
| **Perpetrator DOB:** |  | **Perpetrator Address including postcode:** |  |
| **What is the client’s relationship to the perpetrator?** |  |
|  |
| **Children’s Details:** |
| **How many children are to be considered for safe accommodation:** |  | **Ages of children:** |  |
| **\*\*Confidential Professional Information – not to be shared with client\*\*** |
|  |
| **Referrer Name:** |  |
| **Referring Agency:** |  | **Referring Department:** |  |
| **Referrer Telephone Number:**  |  | **Referrer Email Address:**  |  |

*For further advice and support please contact the Single Point of Access Team on 01522 510041 option 1 or email lincsrefugespa@edan.lincs.org.uk.*