

Please do not print this off and use it to send in a referral it is a checklist

LIDAS INITIAL REFERRAL FORM

LIDAS Reference:

Date of Referral:

All information provided will be treated as confidential

1 Applicant's Details

Name:		
Address:		Is it safe to use? Y/N Alternative?
Post code:		
Phone No.		Is it safe to use? Y/N Is it safe to leave a message? Y/N
NI Number:	Date of Birth:	Age:
Religion		

Safe accommodation	Outreach
Children's Service	Support call
Inappropriate referral	
others	

3 Referred by:

Self	Y / N	Please specify where she heard about LWA:
Agency	Y / N	Please specify which agency and provide the following details:
Name & job title:		
Agency address:		
Phone no:		Email:
If a police referral has a PNC check been done? If so is there are relevant information:		

4 Details of Children

Forename	Surname	M/F	Date of Birth	Location	Open to TAC	CP Plan Y/N
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5 Health Details

Do you have a disability?	Yes	No	Details
Do you have mental health issues?	Yes	No	Details
Do you have a dependency on alcohol?	Yes	No	Details
Do you have a drug dependency?	Yes	No	Details
Are you taking any medication?	Yes	No	Details

6 Financial Details

Are you in employment?	Yes	No	Details
Are you in receipt of benefits?	Yes	No	Details
Do you have recourse to public funds?	Yes	No	Details

7 Historical Information – Refuge Only

Have you been identified as a risk / potential risk to a child / young person?	Yes	No
Have you ever been in refuge before?	Yes	No
If yes, please state where:		
If you have previously been in refuge were you asked to leave?	Yes	No
If yes, please state why:		
Do you have any convictions?	Yes	No
What best describes your current accommodation:		
Do you have any rent arrears, if so how much:		

8 Reason for Referral
<i>Please include all types of abuse experienced</i>
Has there been any police involvement, if so do you have any incident numbers:

9 Risk Assessment	
CURRENT SITUATION THE CONTEXT AND DETAIL OF WHAT IS HAPPENING IS VERY IMPORTANT. THE QUESTIONS HIGHLIGHTED IN BOLD ARE HIGH RISK FACTORS. TICK THE RELEVANT BOX	YES <input type="checkbox"/>
1. Has the current incident resulted in injury?	<input type="checkbox"/>
. Are you very frightened? Comment:	<input type="checkbox"/>
3. What are you afraid of? Is it further injury or violence? (Please give an indication of what you think (name of abuser(s)..... might do and to whom) Kill: Self <input type="checkbox"/> Children <input type="checkbox"/> Other (please specify) <input type="checkbox"/> Further injury and violence: Self <input type="checkbox"/> Children <input type="checkbox"/> Other (please specify) <input type="checkbox"/> Other (please clarify): Self <input type="checkbox"/> Children <input type="checkbox"/> Other (please specify) <input type="checkbox"/>	<input type="checkbox"/>
4. Do you feel isolated from family/ friends i.e. does (name of abuser(s).....) try to stop you from seeing friends/family/Dr or others?	<input type="checkbox"/>
5. Are you feeling depressed or having suicidal thoughts?	<input type="checkbox"/>
6. Is there conflict over child contact?	<input type="checkbox"/>
7. Does (.....) constantly text, call, contact, follow, stalk or harass you? (Please expand to identify what and whether you believe that this is done deliberately to intimidate you? Consider the context and behaviour of what is being done.	<input type="checkbox"/>
CHILDREN/DEPENDENTS (If no children/dependants, please go to the next section)	YES <input type="checkbox"/>
8. Are you currently pregnant or have you recently had a baby in the past 18 months?	<input type="checkbox"/>
9. Are there any children, step-children that aren't (.....) in the household? Or are there other dependants in the household (i.e. older relative)?	<input type="checkbox"/>
10. Has (.....) ever hurt the children/dependants?	<input type="checkbox"/>
11. Has (.....) ever threatened to hurt or kill the children/dependants?	<input type="checkbox"/>
DOMESTIC VIOLENCE HISTORY	YES <input type="checkbox"/>
12. Is the abuse happening more often?	<input type="checkbox"/>
14. Is the abuse getting worse?	<input type="checkbox"/>
15. Has (.....) ever used weapons or objects to hurt you?	<input type="checkbox"/>
16. Has (.....) ever threatened to kill you or someone else and you believed them?	<input type="checkbox"/>
17. Has (.....) ever attempted to strangle/choke/suffocate/drown you?	<input type="checkbox"/>

10 Details of Abuser:
Name of Abuser:
Date of Birth:
Whereabouts if known?
What do they do? Do we need to contact LADO?
Physical description: <ul style="list-style-type: none"> • Height • Build

- Hair colour
- Eye colour
- Facial hair Yes / No
- Glasses Yes / No

Vehicle description:

- Registration Number:
- Make:
- Model:
- Colour:

Are any of the following in place:

• Non-Molestation Order	Yes / No	Valid until:
• Occupation Order	Yes / No	Valid until:
• Restraining Order	Yes / No	Valid until:
• Harassment Warning	Yes / No	Issued on:
• Bail Conditions	Yes / No	Valid until:
• Undertaking	Yes / No	Date given:
• Contact Order	Yes / No	
• Residency Order	Yes / No	
• Prohibitive Steps Order	Yes / No	

Nature and frequency of any contact:

Abusers involvement with other agencies:

Potential triggers:

Additional information / comments:

11 Are you or your children working with any other agency?