Anglia Care Trust
Support • Advice • Action

Domestic Abuse Outreach Service
Referral Form

Type of Support Referring for*			
Crisis Support ☐		Advice and Guidance Support ☐ (In addition to a referral, if you are with a Service User and wish to book an A&G appointment please call 0800 9775690)	
Intensive Support Outreach ☐			
Referrer Details			
Referral Agency		Date of Referral	
Contact Name		Locality (Ipswich / Bury St Edmunds / Lowestoft)	
Contact Telephone Number		Email Address	
Service User Details			
Service User Name* (Also known as)			
Address			
Contact Telephone Number*			
Email address			
Is this a safe number to call?*		Recommended contact method*	
Contact information (eg suitable time to call/leave message)*			

Gender		Date of Birth*	
Accommodation Status		Immigration Status	
Ethnicity		Language Spoken*	
Sexual Orientation		Disability Information	
Religion		Suspected HBV	
Is the Service User pregnant?			
Additional Risk Factors (eg. self harm / mental health / drugs and alcohol)*			

Details of Children *Please complete a separate section for each child:*			
Name of Child		Name of School	
Date of Birth		Gender	
Address			
Involvement with CYP (CP (category of risk) / CIN / CAF)			
Name of Child		Name of School	
Date of Birth		Gender	
Address			
Involvement with CYP (CP (category of risk) / CIN / CAF)			

Name of Child		Name of School	
Date of Birth		Gender	
Address			
Involvement with CYP (CP (category of risk) / CIN / CAF)			
Name of Child		Name of School	
Date of Birth		Gender	
Address			
Involvement with CYP (CP (category of risk) / CIN / CAF)			
Perpetrator Details			
Perpetrator Name/Alias		Date of Birth	
Perpetrator Address			
Relationship to Victim*		Immigration Status	
Additional Risk Factors* e.g. alcohol and drug use/pets/weapons		Are they still in a relationship with the victim?*	
Are they living together?*		If living apart are they likely to visit?	
Description of Perpetrator (e.g. height, hair colour/distinguishing features)			

Reason for Referral			
Background information (including professional opinion)*			
CAADA Risk Assessments Undertaken and score if known (please attach if applicable)		Has the Service User been referred to MARAC? If yes, date of referral/s and case number – if known	
Has consent been given from the Service User?*		If not, do you believe that safeguarding risk overrides this consent?	
Relevant information that may increase risk to the Service User(s) or Professional(s)* nb			
When was the last incident?*			
Who/what does the Service User fear?			
Are there any court orders in place?*			
Details of other agencies supporting the Service User or children*			

Signature of Referrer: ……Date: ……

Signature of Service User …….. Date ……

We will treat your information as confidential and we will not share it with any other organisation unless we are required by law to share it or unless you or any other person will come to some harm if we do not share it. In any case we will only ever share the minimum information we need to share.

Completed referrals should be signed and sent to:

Anglia Care Trust, Unit 8, The Square, Martlesham Heath, Ipswich, Suffolk IP5 3SL
Tel: 01473 622888 Fax: 01473 618660 Email: admin@angliacaretrust.org.uk