

DFV Disability Focus Casework Referral

Servicing Greater Sydney

Please contact DFV Disability Focused team for clarification on referral eligibility if required.

Ph: 0466483858

Email: dfvdisability@jsc.org.au

Eligibility Criteria – MANDATORY QUESTIONS			
Did the client consent to the referral?	<input type="checkbox"/> Yes <input type="checkbox"/> No. <i>(If no, referral cannot be accepted)</i>		
Is there a current ADVO:	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, please provide a copy)</i>		
ADVO conditions:	<input type="checkbox"/> 1abc <input type="checkbox"/> 2 <input type="checkbox"/> 3abc <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6abcd <input type="checkbox"/> 7ab <input type="checkbox"/> 8abc <input type="checkbox"/> 9abc _____ Metres <input type="checkbox"/> 10 <input type="checkbox"/> 11 <input type="checkbox"/> Provisional <input type="checkbox"/> Interim <input type="checkbox"/> Final		
DVSAT:	Score: _____ <i>(please provide a copy)</i> Serious Threat <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, referral to local SAM must have been made)</i>		
Referred to SAM:	<input type="checkbox"/> Yes – Date: <input type="checkbox"/> Location: <input type="checkbox"/> No		
Referred by			
Referring Agency:		Referral Date:	
Referrer Name:		Phone:	
Email:			
Client details			
Name:			DOB:
Residential address:			Does the perpetrator reside at this address? <input type="checkbox"/> Yes <input type="checkbox"/> No
Phone:			Safe to call & leave voice or text messages? <input type="checkbox"/> Yes <input type="checkbox"/> No If safe to contact only at set times, please specify:
Email:			Safe to email? <input type="checkbox"/> Yes <input type="checkbox"/> No
ATSI	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Stated		
CALD	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Stated		
Country of birth:			Year of arrival in Australia:
Migrant/VISA status:			

Language/dialect:	
Proficiency in spoken English:	<input type="checkbox"/> Very well <input type="checkbox"/> Well <input type="checkbox"/> Not well <input type="checkbox"/> Not at all <input type="checkbox"/> Don't know
Interpreter required:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you require written materials?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Disability/Health/Mental Health issues:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Mobility Impairment <input type="checkbox"/> Cognitive/Intellectual Impairment <input type="checkbox"/> Visual Impairment <input type="checkbox"/> Hearing impairment <input type="checkbox"/> Mental Health <i>If yes, please describe:</i>
Is this disability diagnosed:	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, please provide details of who diagnosed (eg, GP, Psychologist, Psychiatrist etc):</i>
Support Needs Related to Disability:	Is the client receiving NDIS? <input type="checkbox"/> Yes <input type="checkbox"/> No
How is the plan managed?	<input type="checkbox"/> NDIA Managed <input type="checkbox"/> Self-Managed <input type="checkbox"/> Other <input type="checkbox"/> Plan managed. Details:
Do you receive disability services:	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, please describe:</i>

Risk to self or others?	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, please describe:</i>
AOD issues:	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, please describe:</i>
Gender Identity:	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> non-binary <input type="checkbox"/> Prefer not to say <input type="checkbox"/> Don't know
Sexual orientation:	<input type="checkbox"/> Straight <input type="checkbox"/> Lesbian <input type="checkbox"/> Gay <input type="checkbox"/> Bi <input type="checkbox"/> Queer <input type="checkbox"/> Other <input type="checkbox"/> Prefer not to say <input type="checkbox"/> Don't know
Marital/Partnership Status:	<input type="checkbox"/> Married <input type="checkbox"/> De-Facto <input type="checkbox"/> Divorced <input type="checkbox"/> Single <input type="checkbox"/> Separated <input type="checkbox"/> Other Length of Relationship:

Other details			
Household tenure: <input type="checkbox"/> Rental <input type="checkbox"/> Mortgage <input type="checkbox"/> Homeless <input type="checkbox"/> Family <input type="checkbox"/> Other (Please specify):		Household composition (List any other adult members of the household): Name: _____ Relationship: _____	
Child Name	Age and Date of Birth	In mother's care	Disability, cognition, or impairment (Inc. mental health) <i>Please specify</i>
		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Is the person being referred pregnant:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are DCJ involved:	<input type="checkbox"/> Yes <input type="checkbox"/> No

Perpetrator Details			
Name:		Date of Birth:	
ATSI <input type="checkbox"/> Yes <input type="checkbox"/> No	Is this Person known by any other name: <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, please provide details:</i>		

Current location/address (e.g. residential/custody):	
Upcoming court matters (local, family, criminal and civil):	
Presenting issues <i>E.G. mental health, AOD</i>	
Warnings/ safety concerns <i>E.G. access to weapons, wanted by Police, OMCG member</i>	

Additional Information

Does the client have any concern for their safety and the children's safety: Yes No Not Stated
If yes, please describe:



Does the person being referred want to remain in their home: Yes No

OTHER SUPPORTS

Are there any other services or agencies involved with the client?

Please specify:

Reason for referral / background of DV history

PLEASE NOTE: If not enough information is provided, the referral may be considered ineligible. This will also avoid the client from having to retell their story. Please include all known current risks and support needs.

Identified needs:





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& Justice



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Please explain the case management supports required