



First Nations Specialist Casework Referral

Please contact for clarification on referral eligibility if required.

Email: DFVFirstNations@isc.org.au

Eligibility Criteria – MANDATORY QUESTIONS				
Did the client consent to the referral?	☐ Yes ☐ No (If no, referral cannot be accepted?)			
Is there a current ADVO:	☐ Yes ☐ No (If yes, please provide a copy) NB: If the client is not willing to pursue an ADVO please explain why in the 'Reason for referral' field			
ADVO conditions:	□ 1abc □ 2 □ 3abc □ 4 □ 5 □ 6abcd □ 7ab □ 8abc □ 9abc Metres □ 10 □ 11 □ Provisional □ Interim □ Final			
DVSAT:	Score: (please provide a copy) Serious Threat □ Yes □ No (If yes, referral to local SAM must have been made)			
Referred to SAM:	□ Yes - Date: □ Location: □ No			
Referred by				
Referring Agency:		Referral Date:		
Referrer Name:		Phone:		
Email:				
Client details				
Name:		DOB:		
Residential address:				
Does the perpetrator reside at this address?		□ Yes □ No		
Phone:				
Safe to call & leave voice or text messages?		□ Yes □ No		
If safe to contact only at set times, please specify:				
Email:		Safe to email? ☐ Yes ☐ No		
First Nations		□ Aboriginal □ Torres Strait Islander □ Both		
Which MOB are you from?				





Country of birth:		Year of arrival in Au	stralia:	
Migrant/VISA status:				
Language/dialect:				
Proficiency in spoken English: Interpreter required:	□ Very well □ Well □ Not well □ Not at all □ Don't know □ Yes □ No			
Disability/Health/ Mental Health issues:	☐ Yes ☐ No If yes, please describe:			
AOD issues:	☐ Yes ☐ No If yes, please describe:			
Gender Identity:	☐ Male ☐ Female ☐ Non-binary ☐ Prefer not to say ☐ Don't know			
Sexual orientation:	□ Straight □ Lesbian □ Gay □ Bi □ Queer □ Other □ Prefer not to say □ Don't know			
Marital/partnership status:	☐ Married ☐ De-Facto ☐ Divorced ☐ Single ☐ Separated ☐ Other			
Length of Relationship:				
Other details				
Household tenure: ☐ Rental ☐ Mortgage ☐ Homeless ☐ Family ☐ Other	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>	
		□ Yes □ No		
		□ Yes □ No		
		□ Yes □ No		
		□ Yes □ No		
		□ Yes □ No		
		□ Yes □ No		
Is the person being referred pregnant:	□ Yes □ No	Are DCJ involved:	☐ Yes ☐ No	





Perpetrator Details				
Name:				
Date of Birth:				
Gender Identity:		Relationship to Client:		
ATSI □ Yes □ No	Is this Person known by any other name: ☐ Yes ☐ No			
☐ Yes ☐ No	If yes, please provide details:			
Current location/address (eg.residential/custody):				
Upcoming court matters (local, family, criminal and civil):				
Presenting issues E.G. mental health, AOD				
Warnings/safety concerns E.G. access to weapons, wanted by Police, OMCG member				
Additional Information				
Does the client have any con If yes, please describe:	cern for their safety and th	ne children's safety: □ Yes □ No □ Not Stated		
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 (Note: don't exceed 550 word count)		
PLEASE NOTE: If not enough information is provided, the referral may be considered ineligible. This will also avoid the client having to retell their story. Please include all known current risks and support needs.		
Explain the case management supports/goals identified/required by the client (Note: don't exceed 400 word count)		