

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?	<input type="checkbox"/> Yes <input type="checkbox"/> No (If no, referral cannot be accepted?)
Is there a current ADVO:	<input type="checkbox"/> Yes <input type="checkbox"/> 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:	<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: _____ (please provide a copy) Serious Threat <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, referral to local SAM must have been made)
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
First Nations	<input type="checkbox"/> Aboriginal <input type="checkbox"/> Torres Strait Islander <input type="checkbox"/> Both
Which MOB are you from?	



Perpetrator Details

Name:

Date of Birth:

Gender Identity:

Relationship to Client:

ATSI

☐ Yes ☐ No

Is this Person known by any other name: ☐ 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 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 *(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)*

