**Please fill out as much of the referral form as possible.**

**Referral Date:**
**Referral Details:**

Name: Organisation:

Job Title: Tel No:

Email Address:

**Woman’s Details:**

Name: DOB:

Address:

Tel No:

Email Address:

Is Woman aware referral is being made?

First Language:

Is an interpreter required?

**Emergency Contact Details:**

Name: Relationship to Woman:

Tel No:

**Other Agencies/Professionals:**

Please detail below any other services or professional’s involvement with the Woman:

|  |
| --- |
|  |

**Safe to Contact By:**

**(IMPORTANT – We cannot accept referrals without the information below. Please indicate Yes or No and add extra contact details where required)**

**Telephone:** Y or N **(delete where appropriate)**

**Text Message** Y or N **(delete where appropriate)**

**Post:** Y or N **(delete where appropriate)**

**Email Address:** Y or N **(delete where appropriate)**

**Emergency Contact:** Y or N **(delete where appropriate)**

**Referring Agency:** Y or N **(delete where appropriate)**

**Children’s Details:
 (delete where appropriate)**

Name: M or F DOB: DD/MM/YYYY

Name: M or F DOB: DD/MM/YYYY

Name: M or F DOB: DD/MM/YYYY

Name: M or F DOB: DD/MM/YYYY

**Social Work Involvement:**

Name of Allocated Worker: Area Team:

Tel No: Email:

Are the Children on the Child Protection Register? Y or N

**Please record any Lead Professional or Named Person’ involved with the children below including contact details:**

|  |
| --- |
|  |

**Which Service do you wish to refer to?**(Please tick all that apply or mark with ‘X’ if using an electronic copy. If you need further information on each service, please contact us)

Support & Advocacy –

1:1 Counselling –

STAAR –

Financial Support –

Family Development –

Children & Young Person –

**(Please note you will be required to complete a further CYP referral if selected)**

Agency Referral:

**Please detail below what support do you consider the Woman and/or Children require from GEWA providing as much detail as possible?**

|  |
| --- |
|  |

**Coping Methods:**

Please provide details of any coping mechanisms that the Woman may use:

|  |  |
| --- | --- |
| Coping Method | Additional Information (Please detail below) |
| **Alcohol** |  |
| **Drugs (Prescription or Illicit)** |  |
| **Gambling** |  |
| **Comfort Eating** |  |
| **Other Methods?** |  |

**Agency Declaration:**

I decare that the information I have given is a full and honest account of my knowledge regarding the person(s) concerned,

Signed:

Print Name:

Date:

**Equal Opportunities Monitoring Form**

It is Glasgow East Women’s Aid policy to treat all job Women who are employed in the service and the Women who use the service fairly and equally, regardless of their sex, trans-gender status, sexual orientation, religion or beliefs, marital status, civil partnership status, age, race, colour, nationality, national or ethnic origins or disability.

The organisation needs your help and co-operation to enable it to do this but filling in this form is **voluntary**.

**Gender:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ or Prefer not to say 🗆

**What is your ethnicity?**

Ethnic origin is not about nationality, place of birth or citizenship. It is about the group to which you perceive you belong. Please detail below:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ or Prefer not to say 🗆

**Do you consider yourself to have a disability or health condition?**

Yes🗆 No 🗆 Prefer not to say 🗆

**What is your sexual orientation:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ orPrefernot to say 🗆

**What is your religion or belief? Please detail below**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ orPrefernot to say 🗆