100 Drummond Street
Carlton Victoria 3053
[03] 9663 6733

Drummond Street Services

Queerspace Family Violence Response Referral Form

To enhance family violence assessment and safety management, please complete this referral form. Incomplete referral forms may be returned for further information gathering purposes.

Queerspace FV Response has two programs open to external referrals:

- **With Respect**: a support program for anybody identifying as LGBTQIA+ who has experienced family violence.
- **Futures Free From Violence**: a support program for those who have caused harm and/or force in family settings and provides group and individual interventions to address this behaviour.

The Queerspace Family Violence Response is prescribed under FVISS and CISS as an ISE and RAE and engage in active information sharing and collaborative practices.

Send us an email or contact us on 03 9663 6733 for any related queries or email this completed form to queerspacefv@ds.org.au

PROGRAM	
Referral for the following program:	☐ With Respect Case Management ☐ With Respect Counselling ☐ Futures Free From Violence
Client Consent	
Yes, I (client name) give consent for (name of referrer) to share my/my family's information with Drummond Street Services for the purpose of a referral to the service. Signature Date: Client Name: Signature: _____ ☐ Verbal Consent	
☐ Yes, I have discussed this referral with my client. Signature date: Referrer's Name: Referrer Signature_____ *To use the referrer signature field, right click on the signature box and select 'Sign'	

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REFERRER DETAILS	
Name	
Position	
Agency Name	
Contact Phone	
Contact Email	
Role in working with the client/family currently	
Will you continue working with the client/family? ☐ Yes ☐ No **Details**	
Presenting issues for client/family *Describe issues, including onset and duration*	
What support is the client seeking?	
What are you, the referrer, seeking from the referral? *Describe the aim of the referral, including any specialist support being sought.*	

CLIENT CONTACT FOR REFERRAL	
Name	
Pronounce	
Is the client known under a different name	
Contact Number	
Contact Email	
Is it safe to use this number	**☐ Yes ☐ No**
Is this a shared phone	**☐ Yes ☐ No**
Can we send a text	**☐ Yes ☐ No**
Can we send an email	**☐ Yes ☐ No**
Can a voicemail be left	**☐ Yes ☐ No**
Best day and time to contact	**☐ No Preference** **☐ Time:** **☐ Day (s):**
Interpreter required?	**☐ Yes ☐ No**
Preferred language or languages (place in order of preference). If it is a specific regional dialect, please specify:	

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CLIENT details				
Gender	Female ☐	Transwoman ☐	Nonbinary ☐	Brotherboy ☐
	Male ☐	Transman ☐	Gender Queer ☐	Sistergirl ☐
	Gender Questioning ☐	Trans unspecified ☐	Agender ☐	Prefer not to say ☐
	Other ☐		Not stated ☐	
Intersex variation	Yes ☐	No ☐	Unsure ☐	
Sexuality	Aromantic ☐	Heterosexual ☐	Questioning ☐	Prefer not to say ☐
	Asexual ☐	Lesbian ☐	Same sex attracted ☐	Other ☐
	Bisexual ☐	Pansexual ☐	Unknown ☐	
	Gay ☐	Queer ☐	Do not identify with any ☐	

DOB	
Address	
Does the client have safe accommodation	
Main language at home	
Country of birth	

Aboriginal or Torres Strait Islander	Aboriginal ☐	Torres Strait Islander ☐	Both ☐	Neither ☐	Prefer not to say ☐
Relationship status	De Facto ☐	De Facto Separated ☐	Divorced ☐	Separated not divorced ☐	
	Married ☐	Single ☐	Self-described ☐	Polygamous ☐	

Highest Level of Education	
Main source of income	
Additional information that enables us making this a more accessible experience for the client?	

Children	
Does the client(s) have children in their care or household?	☐ Yes ☐ No
Is the client pregnant?	☐ Yes ☐ No
Is DFFH Child Protection Services involved?	☐ Yes ☐ No
Is there a current Child Protection Order?	☐ Yes ☐ No
Are there current parenting orders?	☐ Yes ☐ No
Details:	
☐ **Documentation / report attached to referral**	
☐ **No documentation available to referrer**	

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Significant other: Please set out who are involved in the clients life and where FV risk assessment and management is required							
Relationship (partner, parent, child, etc)	Name	DoB	Gender / Sexuality	Address	Phone number	Family Violence Concerns	Which Services are involved
						☐ Yes ☐ No	
						☐ Yes ☐ No	
						☐ Yes ☐ No	
						☐ Yes ☐ No	
						☐ Yes ☐ No	
						☐ Yes ☐ No	

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Family Violence Information

Is your client (please tick all that apply):

☐ Currently experiencing FV
☐ Currently causing harm and/or using force
☐ Have history of experiencing FV
☐ Have a history of causing harm and/or using force

Living arrangements

☐ Living with each other
☐ Not living with each other: details:

Risk of Misidentification? ☐ Yes ☐ No

Details:

Completed MARAM(s) attached to referral:

- ☐ Brief
- ☐ Intermediate
- ☐ Comprehensive

Assessed level of risk as per MARAM:

- ☐ At Risk
- ☐ Elevated Risk
- ☐ Serious Risk

Completed Safety Plan attached to referral:

- ☐ Brief
- ☐ Intermediate
- ☐ Comprehensive

Completed Predominant Aggressor Assessment Tool Attached:

- ☐ Yes
- ☐ No
- ☐ Not applicable

Has Victoria Pol been involved:

- ☐ No
- ☐ Yes:
  - Number of L17's
    - ☐ Documents attached to referral
    - ☐ Not available to referrer

Is there a pending court date:

- ☐ No
- ☐ Yes:

Details:

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Are any Legal Orders in place:

☐ IVO
- ☐ Documents attached to referral
- ☐ Not available to referrer

☐ Family Safety Notice
- ☐ Documents attached to referral
- ☐ Not available to referrer

☐ Community Corrections Order
- ☐ Documents attached to referral
- ☐ Not available to referrer

☐ Other, Details:

- ☐ Documents attached to referral
- ☐ Not available to referrer

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Factors impacting on family health and wellbeing:	Historical:	Current:	Details:
Adult mental health symptoms and/or diagnosis	☐ Yes ☐ No	☐ Yes ☐ No	
Self-Harm	☐ Yes ☐ No	☐ Yes ☐ No	
Suicide Ideation	☐ Yes ☐ No	☐ Yes ☐ No	
Aggressive / unpredictable behaviour	☐ Yes ☐ No	☐ Yes ☐ No	
Emotional, behavioral or mental health symptoms in child	☐ Yes ☐ No	☐ Yes ☐ No	
Failure to attend school and/or disengagement	☐ Yes ☐ No	☐ Yes ☐ No	
Financial Hardship	☐ Yes ☐ No	☐ Yes ☐ No	
Homelessness	☐ Yes ☐ No	☐ Yes ☐ No	
Interpersonal difficulties in child	☐ Yes ☐ No	☐ Yes ☐ No	
Parenting difficulties	☐ Yes ☐ No	☐ Yes ☐ No	
Physical health concerns in child	☐ Yes ☐ No	☐ Yes ☐ No	
Recent stressful event	☐ Yes ☐ No	☐ Yes ☐ No	
Social isolation of family and/or lack of community connections	☐ Yes ☐ No	☐ Yes ☐ No	
Consumption of alcohol and or other drugs	☐ Yes ☐ No	☐ Yes ☐ No	
Additional risk factors such as violence or abuse by community or systems	☐ Yes ☐ No	☐ Yes ☐ No	
Other	☐ Yes ☐ No	☐Yes ☐ No	

Other Services Involved			
Agency	Name	Phone number	Email

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