



Big Rivers Supporting Recovery from Family Domestic and Sexual Violence

Unit 10, 38 First Street, Katherine NT 0850, PO Box 147, Katherine NT 0851
Phone: 1800 714 343 email: dv.bigrivers@kwhb.com.au

ABN 23 351 866 925 | ICN 3068

Big Rivers Healing for Our Mob

Client referral form

Please complete this referral form for culturally safe, specialised care, support and recovery services in the Big Rivers region, Northern Territory. Use this referral as part of a client's ongoing recovery and healing from the impacts of family, domestic and sexual violence.

People who are at **immediate** risk of harm **cannot** be referred to the Big Rivers Healing for Our Mob team. If your client is at immediate risk of harm, **call the police on 000 or 131 444**.

If you believe a **child is being, or has been, harmed or abused** you must report your concerns to the **child protection reporting line on 1800 700 250**. This is a legal responsibility.

The Big Rivers Healing for Our Mob program works with children, young people, and adults who have, or currently are, experiencing harm related to family, domestic and/or sexual violence.

Please complete **Section 1 (pages 2 and 3)** of this form if you are referring a child or young person under the age of 18 years old.

Please complete **Section 2 (pages 4 – 6)** of this form if you are referring a person 18 years and older.

Please complete Sections 1 and 2 if you are referring both a child or young person and an adult into the Big Rivers Healing for Our Mob program.

Please complete **Section 3 (page 7)** – referrer details - for all referrals.

Complete as many questions in this form as you can – it's ok if you can't answer all questions. After this referral is received, a member of the Big Rivers Healing for Our Mob team will speak with your referred client – by phone or face-to-face – to discuss their needs and required support. Please provide the best contact details for your client below – and tell your client someone will contact them over the next few days.

Referrals will be responded to within 5 business days. You will be advised, if your client consents, if the referral is accepted or if an alternative care plan or referral service is recommended.

Email completed forms to dv.bigrivers@kwhb.com.au.

Further information: Call 1800 714 343.

Section 1: Referring a child or young person

Complete this section if you are referring a **child or young person under the age of 18** who is currently experiencing, or has previously experienced, harm related to family, domestic and/or sexual violence. Please complete as much detail as possible.

Child or young person's details

Date of referral:/...../.....
Does the child or young person consent to being referred to the Big Rivers Healing for Our Mob program?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure * This referral can't be processed without your client's consent.
If under 16 years, has the child or young person's safe parent or carer consented to this referral?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
Client's name	
Client's date of birth/...../.....
Sex	<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Indeterminate <input type="checkbox"/> Intersex <input type="checkbox"/> Not stated <input type="checkbox"/> Unknown/inadequately described
Gender	<input type="checkbox"/> Brotherboy <input type="checkbox"/> Cisgender <input type="checkbox"/> Gender non-binary <input type="checkbox"/> Other <input type="checkbox"/> Questioning <input type="checkbox"/> Sistergirl <input type="checkbox"/> Transgender female to male <input type="checkbox"/> Transgender male to female
Indigenous status	<input type="checkbox"/> Aboriginal <input type="checkbox"/> Torres Strait Islander <input type="checkbox"/> Both Aboriginal and Torres Strait Islander <input type="checkbox"/> Neither Aboriginal nor Torres Strait Islander <input type="checkbox"/> Unknown
Is an interpreter required?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure If yes, preferred language?

Please list contact details of client and/or their parent or carer including phone number, address and community	
Is it safe to phone client?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
Safe to leave voicemail?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
Safe to send text message?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
Safe for staff to visit house?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
Best place to meet with the client e.g. at home, at the community health clinic, in Katherine, at the Child and Family Centre (CFC)	
Is the client currently safe from abuse? <i>If no or unsure, please specify:</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
Reason for referral and/or support requested	
Is the client at risk of harming themselves or others? Are there any identifiable risk factors? (e.g. thoughts of suicide, self-harm, risk-taking behaviours, harming others)	
Current supports (e.g. family, friends, GP, sports group, other organisations):	
Client's strengths, resources and/or coping strategies?	
Any additional information	

Section 2: Referring a person aged over 18

Complete this section if you are referring a **person over the age of 18** who is currently experiencing, or has previously experienced, harm related to family, domestic and/or sexual violence. Please complete as much detail as possible.

Client details

Date of referral/...../.....
Does the client consent to being referred to the Big Rivers Healing for Our Mob program?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure * This referral can't be processed without your client's consent.
Client name	
Date of birth/...../.....
Sex	<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Indeterminate <input type="checkbox"/> Intersex <input type="checkbox"/> Not stated <input type="checkbox"/> Unknown/inadequately described
Gender	<input type="checkbox"/> Brotherboy <input type="checkbox"/> Cisgender <input type="checkbox"/> Gender non-binary <input type="checkbox"/> Other <input type="checkbox"/> Questioning <input type="checkbox"/> Sistergirl <input type="checkbox"/> Transgender female to male <input type="checkbox"/> Transgender male to female
Indigenous status	<input type="checkbox"/> Aboriginal <input type="checkbox"/> Torres Strait Islander <input type="checkbox"/> Both Aboriginal and Torres Strait Islander <input type="checkbox"/> Neither Aboriginal nor Torres Strait Islander <input type="checkbox"/> Unknown
Is an interpreter required?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure If yes, preferred language?

Section 3: Referrer details

Name of referrer (person making referral)	
Referrer's role/job title	
Referrer's organisation	
Referrer's type of organisation (select one)	<input type="checkbox"/> Family, domestic and sexual violence (FDSV) service <input type="checkbox"/> Community-controlled health clinic e.g. KWHB, Sunrise or Wurli <input type="checkbox"/> State service (NT Health clinic, hospital or allied health service, Family Safety Framework, Dept of Children & Families) <input type="checkbox"/> Private practice <input type="checkbox"/> Child and maternal health <input type="checkbox"/> First responder (police, ambulance/paramedics) <input type="checkbox"/> Aboriginal Community Controlled Organisation/Health Organisation <input type="checkbox"/> School <input type="checkbox"/> National phone line (e.g. 1800 RESPECT, Lifeline, 13Yarn) <input type="checkbox"/> NA - self-referral <input type="checkbox"/> NA - family <input type="checkbox"/> Other - please specify
Referrer's phone number	
Email	
Client consents to referrer being told about referral outcome	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
If referrer to be advised of referral outcome, method of advice – select one	<input type="checkbox"/> Face to face <input type="checkbox"/> Phone call <input type="checkbox"/> Phone text message <input type="checkbox"/> Phone voicemail <input type="checkbox"/> Email <input type="checkbox"/> Via client <input type="checkbox"/> Other – please specify