**Health Sexual Violence Liaison EXTERNAL REFERRAL FORM**

Please complete this form in all cases of sexual violence disclosures.

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| SEXUAL ABUSE:  ☐ Recent  ☐ Historic | Type of Sexual Abuse:  ☐ Rape  ☐ Sexual Assault (penetration)  ☐ Sexual Assault (no penetration)  ☐ Child Sexual Exploitation  ☐ Stalking  ☐ Online Harassment | ☐ FGM  ☐ Indecent exposure  ☐ Sexual Harassment  ☐ Modern Slavery  ☐ Voyeurism |

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| **If you are a professional making a referral for a client, have any other referrals been submitted:**  ☐ Children’s Social Care  ☐ Adult Social Care  ☐ Paediatric Liaison (internal)  ☐ Other – please specify |
| **Is the referral in relation to Domestic Abuse?**  ☐Yes ☐No  **If yes and you are a professional making a referral for a client, has the domestic abuse risk assessment (DASH) been completed?**The risk assessment can be found on the Intranet under Safeguarding Adults – Domestic Abuse.  ☐Yes – Score? ☐Not applicable |

**Patient Details**

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| --- | --- | --- | --- |
| **Patient Lillie Number (Sexual Health Only):** | **Forename(s):** | | **Surname:** |
| **Gender:** | **Date of Birth:** | | **NHS Number:** |
| **Ethnicity:** | **Religion:** | | **GP Details:** |
| **SAFE means of contact:**  **Mobile:**  **Landline:**  **Other:** | | **Address :**  **County:** | |
| **Best time to contact :** | | **Safe to Post :** ☐Yes ☐No | |

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| **REASON FOR REFERRAL:** | | |
| Is the victim aware of the referral? ☐Yes ☐No  Have they disclosed to the police? ☐Yes ☐No  Police reference number (if known):  Perpetrator Name and relationship to client (if known): | | |
| Does the victim have any additional needs?  ☐ Learning Disability/Difficulties  ☐ Mental Health issues  ☐ Interpreter Required  ☐ Other – please specify | | |
| Risk Factors :  ☐ Substance Misuse  ☐ Uncontrolled Mental Health Problems  ☐ Aggressive  ☐ Known sexual or serious criminal offending  ☐ Poor engagement with professionals  ☐ No fixed abode  ☐ Poses a risk to professionals  ☐ Other – please specify. | | |
| **Other Agency Involved** | **Allocated Worker if Known** | **Contact Tel** |
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| **REFERRER Details:**  **Name:**  **Hospital/Organisation:**  **Dept:**  **Contact:**  **Referral Date:** | | |

**Please return completed referral form to:** [**Soh-tr.safeguardingadults@nhs.net**](mailto:Soh-tr.safeguardingadults@nhs.net)

For any queries please speak to Faye Speed or if unavailable a member of the Safeguarding Team - **Tel: 01704 705248 Mobile: 07818533845**