**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 ☐NoHave they disclosed to the police? ☐Yes ☐NoPolice 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**

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