



Empowering survivors of domestic violence to reclaim their lives

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Referral for Beyond DV

This form to be completed and emailed to info@beyonddv.org.au

- ☐ Must reside in the Brisbane Area
- ☐ Must be out of the abusive relationship for a minimum of three months
- ☐ Able to engage / participate in a recovery-based program

If all these criteria are **not** met the referral will be declined.

Please note: Beyond DV does not offer outreach services but can refer to services that may be able to assist

DATE:

DETAILS OF PERSON BEING REFERRED

Name: _____

Gender: _____ DOB: _____ AGE: _____

Address: _____

Phone: _____ Email: _____

Do you identify as? (circle) Aboriginal / Torres strait Islander / Both / Australian South Sea Islander / None

Country of birth: _____ Language at home: _____

Is an interpreter required? (circle) YES / NO

Is it safe to? (circle) CALL / TEXT / VOICEMAIL / EMAIL

Details of why the referral is being made?

REFERRING AGENCY DETAILS (if Agency referral)

Name of Referring Agency: _____

Name of Referring Worker: _____

Phone : _____ Email: _____

Current Support being offered by agency or other government/non-government agencies:

| Agency | Type: (e.g., case worker) |
|--------|---------------------------|
| | |
| | |
| | |

What supports are the organisations? (circle) Housing, Case Management, Counselling, Financial Support or other?

Give details: _____

CHILDREN AND DEPENDENTS

Full Name: _____

Relationship: DOB: Age:

Gender:

Full Name: _____

Relationship: DOB: Age:

Gender:

Full Name: _____

Relationship: DOB: Age:

Gender:

Full Name: _____

Relationship: DOB: Age:

Gender:

Additional details

Is the person pregnant? (circle) YES / NO

Is there are current Protection Order in place? (circle) YES / NO

Order type: (circle) Temporary / Final / Private / Police

Date of Order: _____ Duration of Order: _____

Are there any safety plans/safety concerns, for the person being referred?

| |
|--|
| |
|--|

Order type: (circle) Private / Court ordered

Date of Order: _____

What are the care arrangements? _____

Is Child Safety involved? (circle) YES/NO

Details of Child Safety Intervention/Involvement? _____

Are there any Mental Health concerns? (circle) YES/NO

Are you on any medication? (circle) YES/NO

Medication details:

Name _____

Dosage _____

Name _____

Dosage _____

Contact person in case of an emergency:

Name _____

Relationship _____ Phone _____

Email _____

Details of Programs *for more information visit www.beyonddv.org.au

Please note: Intake meeting and a Goal Setting appointment are required to access these further opportunities within Beyond DV:

| Programs Offered | Tick for interest |
|---|-------------------|
| Time Out Personnel Development Workshop (only offered certain times of the year) <ul style="list-style-type: none">Builds self-esteems / confidence / self care over several sessions | |
| Extra Time Out Peer Support Morning Tea <ul style="list-style-type: none">Weekly/Fortnightly opportunity to connect with others *School Terms Only* | |
| Pathways to Hope <ul style="list-style-type: none">Career/Study Mentoring / OptionsFinancial Counselling | |
| Hope 4 Life Youth Programs (e.g., homework club, yearly camp, Hangouts) | |
| Bright Start Education Support <ul style="list-style-type: none">Playgroup at Carina Tuesdays and Fridays 9.30am - 11.30am. *School Terms Only* | |
| Counselling: PLEASE NOTE WAIT TIMES APPLY TO COUNSELLING <ul style="list-style-type: none">Six individual sessions are available (50 minutes) Paid for by Beyond DV. **Must have completed the six individual sessions to be eligible for: <ul style="list-style-type: none">Beyond DV Wellness Project Group sessions focusing on Wellness. **Must have completed the Beyond DV Wellness Project to be eligible for: <ul style="list-style-type: none">Shark Cage Therapy - focusing on preventing revictimization PLEASE NOTE WAIT TIMES APPLY TO COUNSELLING. | |

Any other relevant information?

*If any of your details or circumstances change, please inform one of the Beyond DV Team members.

I agree to the following:

- ☐ I understand that Beyond DV is not a crisis service.
- ☐ I can engage/participate in a recovery-based program at a Beyond DV Centre/Hub.

Client Signature:

Client Name:

Date:

OR I have received verbal consent from my client to complete and submit this referral. (If applicable).

Worker Signature:

Worker Name:

Date:

What happens next?

A member of the Beyond DV Team will be in contact to arrange an Intake Meeting. This meeting will be face to face at one of our locations to discuss what Beyond BV can offer and to arrange a Goal Setting appointment.

Please note: Intake meeting and a Goal Setting appointment are required to access further opportunities within Beyond DV

The Beyond DV Team

