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| **CS-F-08 Aviva Whānau Resilience Referral** |

*Please note the primary criteria for this referral is that the person referred is an adult who has experienced or has used family or domestic violence as defined by the Family Violence Act and is in need for long-term support for maintaining the change and continue leading a violence-free life.*

***FIELDS MARKED with (\*) ARE MANDATORY TO BE FILLED******and******EMAIL THIS REFERRAL TO*** [**referral@aviva.org.nz**](mailto:referral@aviva.org.nz)

**Source of Referral:**

|  |  |  |  |
| --- | --- | --- | --- |
| ***\**Organisation:** |  | ***\**Date of Referral:** |  |
| ***\**Referrer Name:** |  | ***\**Referrer’s Contact Details:** |  |

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| --- | --- | --- | --- | --- |
| ***\**Has the client consented to the referral?** | Yes |  | No |  |

***\**Reason for Referral:**

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**Primary Client Information:**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| ***\**Full Name:** |  | | | | ***\**Gender and Pronouns:** | |  |
| ***\**Date of Birth:** |  | | | | ***\** Country of Birth:** | |  |
| ***\**Ethnicity:** |  | | | | ***\**Iwi/Hapu:** | |  |
| ***\**Address:** |  | | | | | | |
| ***\**Phone number:** |  | | | | **Email:** |  | |
| ***\**Is it safe to leave message?** | | Yes | If yes, | Text: | |
|  | | No | | Voicemail: | |

**Details of the Other Person involved:**

|  |  |  |  |
| --- | --- | --- | --- |
| ***\**Name:** |  | **Date of Birth:** |  |
| ***\**Contact Number:** |  | | |
| ***\**Address:** |  | | |
| ***\**Relationship with the Client:** |  | **Length of Relationship:** |  |
| *\****Access to Weapons (if yes, please specify)** |  | ***\**When separated:** |  |
| ***\**Has this person** | Been impacted by family violence | Used family violence | |

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| --- | --- | --- |
| ***\**Has the client engaged with any Family Violence or other Support Agency?** | Yes | If yes, please specify which service: |
| No |

***\**Other whānau/family members:**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Does the client have other whānau/family member? | | | **Yes** |  | | **No** |  | **Unknown** | |
| **Name** | **Contact number** | **Date of Birth** | **Gender** | | **Do they want to engage with whānau resilience (Y/N)** | | | | **Orders in place** |
|  |  |  |  | |  | | | |  |
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***\**Orders:**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Protection Order: | Yes |  | No |  | Unknown |  |
| Parenting Order: | Yes |  | No |  | Unknown |  |

***\**Family Harm experienced:**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Used** | **Exp.** |  | **Used** | **Exp.** |  | **Used** | **Exp.** |
| Physical |  |  | Sexual |  |  | Strangulation/Attempted |  |  |
| Threats |  |  | Emotional |  |  | Weapons used |  |  |
| Intimidation |  |  | Isolation |  |  | Verbal |  |  |
| Harassment |  |  | Spiritual |  |  | Medical treatment denied |  |  |
| Social |  |  | Firearms used |  |  | Financial |  |  |
| Witnessed/heard |  |  | Psychological |  |  | Using children |  |  |

***\**Goals identified for the client: *(please specify the goals identified for the client to engage in the service)***

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***\**Current Safety Issues/Flags:**

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***\**Other Services engaged:**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Service/s** | **Support Worker’s Name** | **Support Worker’s Contact no.** |
| 1. |  |  |  |
| 2. |  |  |  |
| 3. |  |  |  |
| 4. |  |  |  |
| 5. |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| ***\**Any risks for Staff to consider:** | Yes |  | If yes, please specify: |
| No |  |

**Consent and Confidentiality**

The client has the right to privacy in accordance with the Privacy Act 2020. There may be occasions when it is necessary to contact agencies such as Police, Oranga Tamariki, a mental health provider or other social service to ensure the client’s safety or that of someone else. However, where it is considered not in the client’s interests to discuss it because of their own, or someone else’s safety, we will make appropriate referrals without their knowledge.

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| **FOR OFFICE USE ONLY** |
| Contacted by: |
| Date Contacted: |
| Outcome: |