**ADViSE REFERRAL FORM**

(Assessing for Domestic Violence and abuse in Sexual health Environments)

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| **Email:** | [England.advisegm@nhs.net](mailto:England.advisegm@nhs.net) |
| **Office Phone:** | Trafford Domestic Abuse Services- 0161 872 7368 Manchester Women’s Aid – 07706357955/07706357919/07706357919  Tameside Jigsaw - 0161 331 2034  Stockport Without Abuse - 0161 477 4294 |
| Specific will be provided when client is allocated to an advocate educator. Clinicians can contact the relevant above agency and request to speak to the ADViSE project | |

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| Date of Referral |  | |
| Referring Clinician (Name/role) |  | |
| Clinic name/address |  | |
| Clinic phone number |  | |
| Do you have patient consent to make the referral and share patient information?  *(consent must be obtained before a referral is made)* | **YES/NO** | |
| Patient Name |  | |
| Address | **Please highlight patient’s preferred clinic area (clinics covered at end of referral):**  **Trafford**  **Manchester**  **Tameside**  **Stockport** | |
| Date of Birth |  | |
| Language/Interpreter required? |  | |
| Safe telephone number for the patient (or another means by which patient can be contacted)? |  | |
| Is it safe to leave a message/text this number? | **YES/NO** | |
| Are there **ANY** **children under 18 in the household?** (include grandchildren) | **YES/NO** | If so, how many? |
| Are there any vulnerable adults at risk in the family? | **YES/NO** | If so, how many? |
| Family already known to Social Services? | **YES/NO** | **Referred by clinician to?**    **Add local agencies** |
| **Reason for referral to ADViSE….** | | |