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**Bromley & Croydon Women’s Aid**

**IRIS Referral Form**

**How to complete this referral:**

By completing this referral form, you’re helping us to make contact with the client as safely and quickly as possible. We’d appreciate it if you could include as much information as possible - this saves the client from being asked the same questions twice and helps us to understand more about their particular needs and circumstances.

**How to submit this referral:**

To submit your completed document, please email the completed referral form to [iris.croydon@nhs.net](mailto:iris.croydon@nhs.net)

If you have any queries, please contact 0208 313 9303.

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Referral Details**   |  |  | | --- | --- | | Date of referral: |  | | **Please enter your name and contact details:** | | | Referring Clinician (name) |  | | Practice Address |  | | Contact number |  | | Contact email |  | | Is the GP Practice IRIS trained/accredited? | Yes ☐ No ☐ | |

**Consent and Support assessment**

|  |  |
| --- | --- |
| Has the client’s consent been given for this referral? | Yes ☐ No ☐ |
| Family already known to Social Services?  Referred by GP/Clinician to? (Provide local agencies): | Yes ☐ No ☐ |

**Patient’s Details & Contact info**

|  |  |
| --- | --- |
| **Contact information** | |
| First name |  |
| Last name |  |
| DOB |  |
| Language/Interpreter Required? |  |
| **Addresses** | |
| Current address |  |
| Does the perpetrator live at this address? | Yes ☐ No ☐ Don’t Know ☐ |
| 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☐ | |
| **Accessibility requirements** | | | |
| Does this client have any accessibility requirements (for example, hearing loop, braille documents) | Yes ☐  No☐  Don’t Know ☐ | | *If yes, please provide details:* |
| Are there any vulnerable adults at risk in the family? | Yes ☐  No☐  Don’t Know ☐ | |  |

**Children**

|  |
| --- |
| ***If the person being referred has children, please provide details below:*** |

|  |  |  |
| --- | --- | --- |
| Are there **ANY** **children under 18 in the household?** (include grandchildren) | If so, How many? Age? |  |

**Reason for Referral to IRIS:**

|  |
| --- |
| **SIGNIFICANT CONCERNS FLAG:** (eg Staff Safety Issues/Serial Or Repeat Perpetrator/HBV/Suicide Or Self Harm Concerns/Known To MARAC) Please also |
|  |

Thanks for taking the time to complete this referral.