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| **Date of Referral:**  | **Has the client consented to referral?** [ ]  Yes [ ]  No ***Referrals will not be accepted without the consent of the client*** |
| **Have you checked the Eligibility criteria on page 3 of this form?** [ ] Yes [ ]  No | **Are they still living with the Alleged Perpetrator?** [ ] Yes [ ]  No ***Please note that we cannot accept referrals if the client is still living with the Alleged Perpetrator.***  |
| **Client’s Details:** |
| Name: NHS No. if known: | DOB: | Gender: Choose an item. |
|
| Address: Postcode:Is this a safe address to send correspondence to?[ ] Yes [ ]  No | Telephone number:Email address:Preferred method of contact:Is it safe to leave a message on this contact number?[ ] Yes [ ]  No |
|
| Ethnicity: Choose an item. | Language Spoken: Requires Interpreter?  Choose an item. |
| Religion:  | Do you have a disability or long term health condition? |
| Relationship Status: | Sexual Orientation: Choose an item. |
| Does the client have any children?  | [ ]  Yes | [ ]  No |
| If so, please provide their names and DOB: |
| Is the client the main carer for these children?  | [ ]  Yes | [ ]  No |
| Are the children known to children’s services? Please specify the status: LAC/CIN/CP | [ ]  Yes | [ ]  No |
| **Referrer Details:** |
| Name:  | Organisation and Position: |
|
| Address:  | Email:  |
| Phone:  | Fax:  |
| Does the client have a **history of domestic abuse?** Please provide more details below | [ ]  Yes | [ ]  No |
| Has a **risk assessment** been completed for this client? Please attach with this referral | [ ]  Yes | [ ]  No |
| Has a referral to **MARAC** been completed?  | [ ]  Yes | [ ]  No |
| Has this crime been reported to the police? | [ ]  Yes | [ ]  No |
| **Reason/s For Referral** (P*lease include any information which may be useful to assist with the referral e.g. information related to domestic abuse, mental health, drug and alcohol, vocational/educational, physical health, including past/current risk assessments).*  |
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| **Name of GP**:  | Surgery/Practice/Clinic: |
|
| Address:  | Email:  |
| Phone:  | Fax:  |
| **Is the client linked in with any other services? e.g. social services, drug & alcohol services, mental health services, probation etc.** If yes, please provide details:  |
| **Eligibility Criteria for BRAVE:*** Women and men who have been in violent and/or abuse relationships and experience psychological/emotional difﬁculties (for example low mood, anxiety, trauma symptoms).
* Living in Berkshire.
* Must be safely away from the alleged perpetrator.
* Over 18 years old.
* Willing to learn new skills to manage emotions to avoid longer term difﬁculties.
* Be open to a small group intervention (groups will be single sex). Individuals will not be asked to talk about their stories or experiences in the group. Currently all groups are being held online.

**Exclusion Criteria:*** Clients with substance misuse issues that may be the primary problem or may interfere with ability to make use of treatment.
* Contra- indicators to therapy may significantly increase risk or the client cannot engage because of situational, environmental, practical, or social reasons e.g., on-going legal proceedings, homelessness etc.
* Individuals who are engaging in other forms of therapy
* Clients who have enduring mental health challenges which may be better served by secondary mental health teams.
* Inclusion and exclusion criteria are considered on a case-by-case basis.
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**Risk Assessment**

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| **Risk of Suicide/ Harm to Self** |
| **Risk of Accidental/Unintentional harm to Self** |
| **Risk of Harm to Others** |
| **Risk of Harm from Others and Vulnerability** |
| **Other Risks - Including Falls And Or Physical Health Risks (please provide further details not mentioned above)** |

**Please return the completed referral form and updated risk assessment to:** **Brave@berkshire.nhs.uk**