RASASC REFERRAL FORM

Please confirm that the individual has given consent for this RASASC referral, and it is safe to make contact via telephone and post. Please delete as appropriate: Yes / No

Ref No:

Client informed of confidentiality limitations and database use □
(If it is not safe then please identify below and provide alternative safe contact details)

Please complete the referral form with as much detail as possible. The **minimum** information required is highlighted in red. Without this information, we cannot process the referral.

CLIENT'S NAME:	REFERRAL DATE:
CLIENT'S ADDRESS:	CLIENT'S CONTACT NO: Alternative no. if phone seized by police: CLIENTS EMAIL ADDRESS:
TOWN:	POST CODE:

DATE OF BIRTH:		AGE		IF UNDER 16'S COMPLETE APPENDIX 1

REFERRING ORGANISATION:	NAME & TITLE OF PERSON MAKING REFERRAL:
REFERRER'S TEL NO. EMAIL ADDRESS:	NATURE OF YOUR INVOLVEMENT:

Ok to send post	YES		NO		Ok to leave a telephone message	YES		NO		OK to send text	YES		NO	

DETAILS OF INCIDENT/POLICE/SARC

REPORTED TO THE POLICE	YES		NO		INCIDENT NUMBER:	
POLICE DIVISION:					INVESTIGATING OFFICER:	
STATUS OF POLICE INVESTIGATION:						
HAS THE CLIENT ATTENDED SARC (SEXUAL ASSAULT REFERRAL CENTRE)?	YES		NO			
IF YES PLEASE CONFIRM DATE OF FORENSIC EXAMINATION:						
IF NO PLEASE STATE WHY:						
HAS THE CLIENT HAD SEXUAL HEALTH CHECKS?	YES		NO			
DATE OF ASSAULT OR APPROXIMATE PERIOD OF ABUSE:					AGE AT TIME OF ASSAULT:	

TYPE OF ASSAULT :	RAPE		CHILDHOOD SEXUAL ABUSE		SEXUAL VIOLENCE		OTHER	

PERPETRATOR RELATIONSHIP TO CLIENT, PLEASE SPECIFY MALE OR FEMALE.

PLEASE DETAIL NATURE OF INCIDENT AND CLIENT SUPPORT NEEDS.

RASASC REFERRAL FORM

LIVING WITH: ALONE / PARTNER / CHILDREN / RELATIVE / CARER				
NUMBER OF DEPENDENTS (UNDER 18S)	MALE		FEMALE	
GP DETAILS:				

CLIENT **DISABILITY:** If a client considers themselves to have a disability please select the most appropriate definition. If the client has multiple disabilities please select the definition that reflects the predominant disability.

Not Considered Disabled		Mental Health Issues		Other	
Physical Impairment		Learning Disability/Difficulty		Unknown	
Sensory Impairment		Long Standing Illness or Health Condition			

IF ANY OF THE ABOVE BOXES ARE TICKED, PLEASE PROVIDE FURTHER DETAILS INCLUDING ANY FORMAL DIAGNOSIS.

STATUTORY FRAMEWORKS: Does the client have any involvement with the following. Please mark all that apply:

MARAC		Probation / Youth Offending		Homeless	
MAPPA		Social Care		CAMHS	
ASBO		Drug / Alcohol Intervention		Other	

PLEASE STATE IF THE CLIENT IS OPEN TO ANY OTHER AGENCIES/SERVICES AND IF THE CLIENT POSES ANY POTENTIAL RISK TO THEMSELVES OR OTHER PROFESSIONALS. PLEASE GIVE NAME AND CONTACT DETAILS OF ANY WORKERS INVOLVED.

OFFICE USE ONLY

Actions taken

_____

_____

_____

_____

_____

_____

Referral Taken by…… Database updated Y / N: Updated by: ……..
Allocated Worker…….. IA Date:……. IA Location:……

PLEASE RETURN VIA EMAIL: support@rapecentre.org.uk / caz.battersby@rasasc.cjsm.net
OR VIA FAX: 01925 634636
For any queries regarding a referral please contact RASASC on 0330 363 0063 or 01925 221546

RASASC REFERRAL FORM

APPENDIX 1
CHILREN UNDER 16

SAFEGUARDING INFORMATION: Is this child/young person open to any of the following:

Social Care		Child Protection Plan		Child In Need			
Looked After Child		Subject to care order		CAF			

IF ANY OF THE ABOVE BOXES ARE TICKED, PLEASE PROVIDE FURTHER DETAILS. PLEASE GIVE NAMES AND CONTACT DETAILS.

WHO DOES THE YOUNG PERSON / CHILD LIVE WITH:
If address differs from parent/carer please state:

IS THE CHILDS PARENT/CARER AWARE OF THIS REFERRAL	YES		NO	

IF TICKED NO PLEASE PROVIDE FURTHER DETAILS:

OFFICE USE ONLY

Actions taken

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Referral Taken by…… Database updated Y / N: Updated by: ……....

Allocated Worker…….. IA Date:…….. IA Location:……

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