|  |  |  |  |
| --- | --- | --- | --- |
| **Referral** | | | |
| Referrer Name: |  | Referrer Email: |  |
| Referral Agency: |  | Phone Number: |  |
| Referral Date: |  |  | |
| Referral Source: | | | |
| Action Fraud  Beacon Outreach  British Transport Police  CAB Witness Service  DV Specialist Support  Hertfordshire Police  Housing Association  Local Authority  Social Services  SV Specialist Support  Voluntary/Community Group  Witness Care Unit  Other (Please Specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| Referral Agency Location: | |  | |
| Crime Reference Number (if applicable): | |  | |

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| **Client Details** | | | |
| Title: | | | |
| Mr  Mrs  Ms  Miss  Other (Please Specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| First Name: |  | Surname: |  |
| DOB: |  |  | |
| Address: | | | |
|  | | | |
| Postcode: | |  | |
| Telephone Number: |  | Mobile Number: |  |
| Email: |  | | |
| Preferred/Safe Method of Contact |  | | |
| Best Time to Contact |  | | |
| Has the Victim Given Consent to be Referred to Beacon? | | Yes  No (If no, please obtain consent as we are unable to work with victims of crime without consent) | |
| Gender: | | | |
| Male  Female  Trans  Indeterminate  Andogyny  Bigender  Gender Binary  Gender Fluid  Intersex  Questioning (Gender)  Third Gender/Pangender  Other  Prefer not to say  Unknown  Not Given | | | |
| Ethnicity: | |  | |
| Disabilities: | | | |
| Autistic Spectrum Disorder  Blind or Partially Sighted  Deaf or Hearing Impairment  Disability, Special Need or Medical Condition  Mental Health Difficulties  Specific Learning Difficulty  Unseen Disability (or diabetes, epilepsy)  Wheelchair User/Mobility Difficulty  Prefer Not to Say  Unknown  No Disabilities | | | |
| Religion: | | | |
| Christian (all denominations)  Buddhist  Hindu  Jewish  Muslim  Sikh  Other Religion  No Religion  Prefer Not to Say  Unknown | | | |
| Sexual Orientation: | | | |
| Gay  Lesbian  Heterosexual  Bisexual  Androsexual/Androphillic  Aromantic  Asexual  Bicurious  Demisexual  Fluid sexuality  Pansexual  Questioning (Sexual)  Skoliosexual  Other  Prefer Not to Say  Unknown | | | |
| Any Communication Issues? | |  | |

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| --- |
| **Risk** |
| Would you consider it safe to visit this service user at home? |
| Yes  No |
| Please list any locations at which we should not meet with the service user: |
|  |
| Please list any specific known risk posed by service users to staff, the public or other service users which is relevant for us to be aware of to enable us to provide a support service to victim: |
|  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Crime Information:** | | | |
| Crime Type: |  | | |
| Incident Date: |  | Reported to Police? | Yes  No |
| Crime Reference Number: | |  | |
| Offender Known? | | Yes  No | |
| Incident Details: | | | |
|  | | | |