**Fresh Start Agency Referral Form**

Fresh Start delivers a programme of interventions for perpetrators of intimate partner abuse alongside a service for their partners/ex-partners.

Fresh Start is funded for clients who live in Milton Keynes. Clients who live outside of Milton Keynes can be referred on to (or self-refer onto) the program but this will incur a cost.

Fresh Start is for Clients who….

* Agree to be assessed for their suitability for the programme
* Can attend regular weekly sessions– See below for programme time frames. *Clients will only be offered the 121 programme if there are barriers identified which would make it difficult for them to access the group programme.*

Group Programme: 32 weeks

121 Programme: 18-26 sessions

* Understand that their partners / ex partners will be offered a support service

As it may mean that they are not eligible for our service please contact us before referral if your client is currently

* Awaiting the outcome of a criminal justice process
* In private law proceedings over child contact.
* Under-taking or waiting to start another Domestic Abuse programme.
* Attending other counseling and / or therapy

Please Attach:

* Child Protection/Child in Need plan
* On-going proceedings
* Any relevant paperwork/information

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of Referrer** |  | **Date:** |  |
| **Agency** |  | | |
| **Address** |  | | |
| **Telephone Numbers** |  | | |
| **Email Address** |  | | |

**(Details of the person being referred who has used violent/abusive behavior)**

|  |  |
| --- | --- |
| **Client Name** |  |
| Date of Birth |  |
| Address |  |
| Telephone Numbers |  |
| Email Address |  |
| Gender |  |
| Has the client consented to the referral? |  |

**Accessibility Requirements:**

|  |  |
| --- | --- |
| Has Specific Requirements (e.g. wheelchair ramp, hearing loop) |  |
| Interpreter Required (British Sign Language, or language) |  |
| Primary Language |  |

***Please provide contact details for the current partner or most recent ex-partner***

|  |  |
| --- | --- |
| **Name** |  |
| Date of Birth |  |
| Email Address |  |
| Telephone Numbers |  |
| Address |  |
| Postcode |  |
| Ethnicity |  |
| Gender (Male, female, or transgender) |  |
| Employment Status |  |
| Sexuality (Heterosexual, gay, lesbian, bi, other, prefer not to say) |  |

***Please provide contact details for any other ex-partner***

|  |  |
| --- | --- |
| **Name** |  |
| Date of Birth |  |
| Email Address |  |
| Telephone Numbers |  |
| Address |  |
| Postcode |  |
| Ethnicity |  |
| Gender (Male, female, or transgender) |  |
| Employment Status |  |
| Sexuality (Heterosexual, gay, lesbian, bi, other, prefer not to say) |  |

**Please give details of children, biological, step or otherwise?**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Name** | **D.O.B** | **Gender** | **Mother** | **Father** | **Living** | **Who has parental responsibility** | **Type of contact with child** |
|  |  |  |  |  |  |  |  |
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**Relationship Status:-**

|  |  |
| --- | --- |
| Relationship Status |  |
| Other relevant relationship information |  |

**What has prompted this referral?**

**Date and details of the most recent incident with partner/ ex-partner?**

**Are there any orders prohibiting the client from having contact with his partner or children?** *(Please provide details)*

**Please provide details of any safeguarding measures in place around the child/children of the current family** (E.g., Child Protection Plan, Child In Need, CAF, or TAC)**?**

**Has the Client ever been in the Armed Forces?**

**Is there any involvement with the family by other agencies?** *(Please provide contact details)*

**Are there any outstanding or ongoing criminal proceedings?**

**Are there any outstanding or ongoing court proceedings regarding children, Please specify if public or private?**

**Is the client currently engaging with, or been referred for, any other form of therapy or counselling?** (*Please give details)*

**Has the victim ever been referred to Marac (Multi Agency Risk Assessment Conference)?**

(*Please provide date if known)*

**Has the client ever been referred to MAPPA (Multi Agency Public Protection Arrangements)?**

**Has the client previously been referred into, started, or completed any other Domestic Violence Perpetrator Programme?** *(Please provide details)*

**Additional Support Needs:-**

|  |  |
| --- | --- |
| **Mental Health Support Need** |  |
| Please explain (including any involvement by any Mental Health Services): | |
| **Physical Health Support Need** |  |
| Please explain: |  |
| **Drug Support Need** |  |
| Please explain: (including any interventions by any Drug Services) |  |
| **Alcohol Support Need** |  |
| Please explain: (including any interventions by any Alcohol Services) |  |
| **Offending Behavior history** |  |
| Please explain: |  |

**Equalities Monitoring:-**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Gender | |  | | |
| Transgender | |  | | |
| Sexual Orientation |  | | | |
| Ethnicity | |  | | |
| Ethnicity Other | |  | | |
| Disability | |  | | |
| Physical Disability | |  | | |
| Learning Disability | |  | | |
| Hearing Disability | |  | | |
| Vision Disability | |  | | |
| Mental Health Disability | |  | | |
| Long Term Condition | |  | | |
| Speech Impairment | |  | | |
| Religion | | |  |
| Religion Other | | |  |

***Any other information relevant to this referral?***