Carrie's Place External Referral Form (SP-FOR-019)

Please use this form to refer to the following programs of Carrie's Place:

Specialist Homelessness Services (SHS)

Target group: Individuals and families who are homeless or at risk of homelessness with barriers to resolving their own homelessness in the Maitland, Cessnock, and Dungog LGA's (accepting clients of all gender identities).

Our specialist homelessness service provides accommodation and outreach support services. This program includes outreach support, as well as some short term /emergency accommodation (female identifying only) and transitional accommodation (accepting clients of all gender identities). This program involves intake and case management.

*Please note: Carrie's Place are not a crisis service.
To access emergency temporary accommodation, please call:
Link2Home - 1800 152 152
DV Hotline - 1800 656 463

Or contact the local Community Housing Providers:
Hume Housing - 1800 004 300
Home in Place - 1300 333 733

Send completed form to intake@carriesplace.org.au or phone (02) 4934 2585 and select Option 1.

Staying Home Leaving Violence (SHLV)

Target group: Women who have experienced domestic violence in the Maitland, Cessnock, Dungog, Singleton, Muswellbrook, and Upper Hunter LGAs.

Our SHLV program provides support to women to stay safely in their own home. This may include case management support, safety planning, and security upgrades.

Send completed form to intake@carriesplace.org.au or phone (02) 4934 2585 and select Option 1.

Hunter Valley Women's Domestic Violence Court Advocacy Services (HVWDVCAS)

Target group: Women who have experienced domestic and family violence – this program covers the following local courts: Maitland, Kurri, Cessnock, Singleton, Muswellbrook, Scone, Dungog and Port Stephens.

Our HVWDVCAS program provides information about AVO's, explains the court process relating to AVO's and related charges, provides support and advocacy at court and within the justice system, refers to other services, and provides assistance to access legal representation in some instances.

Send completed form to intakedvp@carriesplace.org.au or phone (02) 4934 2585 and select Option 2.

Local Coordination Point (LCP)

Target group: Women who have experienced domestic and family violence in the Port Stephens-Hunter and Hunter Valley Police District Area Commands (see above courts).

Carrie's Place Local Coordination Point responds to referrals from Police and other agencies for women who have experienced domestic or family violence. The LCP offers support and referrals, advocacy and liaison with Police and the justice system, safety planning, and support for immediate needs. Referrals to the LCP can also include referrals for clients who have been assessed to be at Serious Threat and may need to be referred to a Safety Action Meeting (SAM) to coordinate safety actions – please request and complete Safer Pathway referral form for SAM referrals.

Send completed form to intakedvp@carriesplace.org.au or phone (02) 4934 2585 and select Option 2.

Group Work

Carrie's Place offers groups including domestic violence education groups. Please visit our website to see what is currently available before referring or email groupprograms@carriesplace.org.au.

Some of the information requested may not be known to you. Please complete this form with as much information as you have access to. This supports us to triage and reduces incidents of clients having to re-tell their story.

Date of Completion:	

Referrer Details			
First Name:		Last Name:	
Organisation (optional):			
Contact Number:			
Email Address:			

Client Details			
First Name:		Last Name:	
Date of Birth:			
Gender Identity:	☐ Female ☐ Male ☐ Prefer not to say ☐ Other		
If other, please specify:			
Pronouns:	☐ She/Her ☐ He/Him ☐ They/Them ☐ Prefer not to say ☐ Other		
If other, please specify:			

Client Contact Details	
Contact Number:	
Email Address:	
Current Address:	
Is it safe for us to:	☐ Call ☐ Leave a voicemail ☐ Text ☐ Email ☐ Post to address listed
Relationship Status:	☐ Single ☐ Partnered

Partner's Information (if applicable)			
First Name:		Last Name:	
Gender Identity:	☐ Female ☐ Male ☐ Prefer not to say ☐ Other		
If other, please specify:			
Date of Birth:	Day / Month / Year		
Country of Birth:			
Do they identify as Aboriginal or Torres Strait Islander?:	☐ No ☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander ☐ Yes, both Aboriginal and Torres Strait Islander ☐ Unknown		
Usual Place of Residence:			

(02) 4934 2585 | carriesplace.org.au | First Floor, Unit 12/116 High Street, East Maitland NSW 2323

Client Demographics	
Does the client identify as Aboriginal or Torres Strait Islander?:	☐ No ☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander ☐ Yes, both Aboriginal and Torres Strait Islander ☐ Unknown
Country of Birth:	
If relevant, year of arrival in Australia:	
Culturally and Linguistically Diverse:	☐ Yes ☐ No
Main language spoken at home:	
If applicable, other language spoken at home:	
Does the client prefer to use an interpreter?:	☐ Yes ☐ No
Does the client identify as LGBTQIA+?:	☐ Lesbian, Gay or Homosexual ☐ Straight or Heterosexual ☐ Bisexual ☐ Queer ☐ Prefer not to say ☐ Different Identity ☐ Unknown
Different Identity (if relevant):	

Please continue on to the next page.

If the client does not have children, please skip to page 6.

Children's Information			
Child 1 (if applicable)			
First Name:		Last Name:	
Gender Identity:	☐ Female ☐ Male ☐ Prefer not to say ☐ Other		
If other, please specify:			
Date of Birth:	Day / Month / Year	Disability: ☐ Yes ☐ No ☐ Unknown	
Country of Birth:			
Are they Aboriginal or Torres Strait Islander?:	☐ No ☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander ☐ Yes, both Aboriginal and Torres Strait Islander ☐ Unknown		
Usual Place of Residence:			

Child 2 (if applicable)			
First Name:		Last Name:	
Gender Identity:	☐ Female ☐ Male ☐ Prefer not to say ☐ Other		
If other, please specify:			
Date of Birth:	Day / Month / Year	Disability: ☐ Yes ☐ No ☐ Unknown	
Country of Birth:			
Are they Aboriginal or Torres Strait Islander?:	☐ No ☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander ☐ Yes, both Aboriginal and Torres Strait Islander ☐ Unknown		
Usual Place of Residence:			

Child 3 (if applicable)			
First Name:		Last Name:	
Gender Identity:	☐ Female ☐ Male ☐ Prefer not to say ☐ Other		
If other, please specify:			
Date of Birth:	Day / Month / Year	Disability: ☐ Yes ☐ No ☐ Unknown	
Country of Birth:			
Are they Aboriginal or Torres Strait Islander?:	☐ No ☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander ☐ Yes, both Aboriginal and Torres Strait Islander ☐ Unknown		
Usual Place of Residence:			

If the client does not have other significant persons, please skip to the next question (Referral for Support).

Other Significant Persons			
Person 1 (if applicable)			
First Name:		Last Name:	
Gender Identity:	☐ Female ☐ Male ☐ Prefer not to say ☐ Other		
If other, please specify:			
Date of Birth:	Day / Month / Year		
Country of Birth:			
Do they identify as Aboriginal or Torres Strait Islander?:	☐ No ☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander ☐ Yes, both Aboriginal and Torres Strait Islander ☐ Unknown		
Relationship to Client:			

Referral for Support	
Program referring to:	☐ Lower Hunter Homelessness Specialist Services (SHS) ☐ Staying Home Leaving Violence (SHLV) ☐ Domestic Violence Court Advocacy Services (DVCAS) ☐ Legal Appointment ☐ Group Work ☐ Other
Accommodation Options:	☐ Supported Temporary Accommodation ☐ Women and Children's Refuge ☐ Short Term DV Accommodation (up to 28 days) ☐ Transitional Accommodation
What supports are you providing to this client and will this support continue following the referral?:	
Primary reason for referral:	

Current Client Status	
Accommodation (if applicable)	
Does the client have somewhere safe to stay tonight?:	☐ Yes ☐ No ☐ I'm not sure ☐ Other
How long can the client stay there?:	
Type of accommodation? (e.g. community housing, rental, homeowner, transitional accommodation etc.):	
Barriers to resolving own accommodation issues (e.g. TICA):	
If you have any further comments about the client's Accommodation status, please enter the details here.	

Domestic Violence (if applicable)			
Please explain current risk and circumstances and/or most recent incident:			
Perpetrator's Full Name:			
Perpetrator's DOB:	Day / Month / Year		
Police Involvement?:	☐ Yes ☐ No ☐ I'm not sure		
Date of last incident:	Day / Month / Year		
Is there an existing AVO:	☐ Yes ☐ No ☐ I'm not sure		
AVO Expiry Date (if known):	Day / Month / Year		
AVO Conditions (if known):			
Is the client At Threat (AT):	☐ Yes ☐ No ☐ I'm not sure	Is the client at Serious Threat (ST): ☐	☐ Yes ☐ No ☐ I'm not sure
Are you aware of any breaches? If so, please provide details:			
If you have any further comments about the client's Domestic Violence status, please enter the details here.			

Mental Health (if applicable)	
Condition (diagnosed or undiagnosed):	
Treatment plan, if any (including medication):	
Treatment compliance:	☐ Yes ☐ No
Any current risk to self or others:	
If you have any further comments about the client's Mental Health status, please enter the details here.	

Disability (if applicable)				
Intellectual?:	☐ Yes ☐ No	Learning Disorder?:	☐ Yes ☐ No	
Psychiatric?:	☐ Yes ☐ No	Physical?:	☐ Yes ☐ No	
Other:				
Any supports in place?:				
If you have any further comments about the client's Disability status, please enter the details here.				

Health (if applicable)	
Condition (diagnosed or undiagnosed):	
Treatment plan, if any (including medication):	
Treatment compliance:	☐ Yes ☐ No
If you have any further comments about the client's Health status, please enter the details here.	

Financial (if applicable)			
Type of income:		Fortnightly amount:	
If you have any further comments about the client's Financial status, please enter the details here.			

Child Protection (if applicable)	
Current concerns:	
FACS involvement:	☐ Yes ☐ No ☐ I'm not sure
Family Law proceedings/orders:	☐ Yes ☐ No ☐ I'm not sure
If you have any further comments about the client's Child Protection status, please enter the details here.	

Behaviour Concerns (if applicable)	
Treatment compliance:	☐ Yes ☐ No ☐ I'm not sure
If yes, please provide details:	
Probation and Parole Involvement:	
Risk Taking Behaviour:	
If you have any further comments about the client's Behaviour Concerns status, please enter the details here.	

Legal Issues (if applicable)	
Outstanding court appearances:	
Charges:	
If you have any further comments about the client's Legal Issues status, please enter the details here.	

Other (if applicable)	
Please include any other relevant information:	
What other referrals have been made for this client?:	
What other services is the client currently engaged with (include contact details if known)?:	

You may obtain verbal or written consent from the client to make this referral*. Please note, all programs of Carrie's Place Inc are voluntary. Complete relevant Consent below.

**Referrals received without consent will not be accepted.*

Written Consent from Client:

☐ I _____ (*name*) consent for my information to be sent to Carrie's Place Domestic Violence and Homelessness Services for the purpose of a referral.

☐ I consent to the two-way sharing of relevant information between my referrer and Carrie's Place Domestic Violence and Homelessness Services to help understand my needs and provide appropriate support.

Signature:	
Date Signed:	

Verbal Consent from Client:

☐ I _____ (*referrer*) of _____ (*insert agency name*) obtained the verbal consent of _____ (*insert client name*) for this agency to collect, hold, and send the client's personal information to Carrie's Place Domestic Violence and Homelessness Services Inc. for the purpose of a referral.

☐ I consent to the two-way sharing of relevant information between my referrer and Carrie's Place Domestic Violence and Homelessness Services to help understand my needs and provide appropriate support.

Signature:	
Date Signed:	

To submit, please email your completed External Referral Form to intake@carriesplace.org.au.

If you have any questions, please call us on (02) 4934 2585.