Catholic Care Social Services Hunter-Manning
DIOCESE OF MAITLAND-NEWCASTLE

32-34 Pulteney St
Taree NSW 2430
Ph: 02 6539 5900
Fax: 02 6539 5979
IDFVS@catholiccare.org.aU

RENEWING PATHWAYS REFERRAL FORM

Referrer Details

Organisation: _____

Position: _____

Phone Number: _____ Fax Number: _____

Email: _____

Role / relationship to client: _____

Date: _____

Primary Client Details

Name: _____

Other Names: (maiden, alias, etc.) _____

Date of birth: _____ Gender: _____

Address: _____

Email: _____

Phone: _____ Safe to call? ☐ Yes ☐ No

Safe to leave voice message? ☐ Yes ☐ No Safe to text message? ☐ Yes ☐ No

Identifies as: ☐ Aboriginal ☐ Torres Strait Islander ☐ Both ☐ Neither ☐ CALD

Country of Birth: _____

Language spoken at home _____

Disability / Illness: _____

Currently pregnant? ☐ Yes ☐ No Weeks gestation: _____

Dependants / Other Household Members (Note: do not list Person Causing Harm here)

Name	Date of Birth	Gender	Relationship to Client	Identifies as	Country of Birth	School / CCC

NB: Please indicate variations of address and known disabilities / illnesses for persons listed here as well as additional persons in "Other Information" on page 4

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Person Causing Harm Details

Name: _____

Previous Name: (maiden, alias, etc.) _____

Date of Birth: _____ Gender: _____

Usual Address: _____

Email: _____

Phone: _____

Identifies as: ☐ Aboriginal ☐ Torres Strait Islander ☐ Both ☐ Neither ☐ CALD

Country of Birth: _____

Language spoken at home _____

Disability / Illness: _____

Currently incarcerated: ☐ Yes ☐ No Expected Release Date: _____

Location: _____ MIN: _____

Known Charges: _____

Current Housing Details

☐ Owner ☐ Private Rental ☐ Public/Community Housing ☐ Homeless

☐ Other (please specify) _____

Are the clients safe in their current housing? YES ☐ NO ☐

Other Support Service Involvement

Organisation: _____ Start Date: _____

Contact Name: _____ Phone: _____

Reason for engagement: _____

Organisation: _____ Start Date: _____

Contact Name: _____ Phone: _____

Reason for engagement: _____

Organisation: _____ Start Date: _____

Contact Name: _____ Phone: _____

Reason for engagement: _____

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Current / Ongoing Court Matters

ADVO: ☐ Yes ☐ No ☐ Not known

Conditions: Expiry:

FLC Orders: ☐ Yes ☐ No ☐ Not known

Details:

Children's Court Orders: ☐ Yes ☐ No ☐ Not known

Details:

Other: (eg. Bail conditions, impending court dates) ☐ Yes ☐ No ☐ Not known

Details:

Further Information:

Note: Please attach copies of any relevant orders / information to this referral

Reason for Referral

☐ DV ☐ FV ☐ Safety Planning
☐ FLC ☐ Victims Services ☐ ADVO Support
☐ DFV Education ☐ Other (please specify)

Note: Reasons listed in "Other" will be assessed for suitability)

Event triggering referral:

Is this a referral to this service? ☐ YES ☐ NO ☐ Not known

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Further Information:

Other Information

Known Risks to Workers Safety

Office Use Only

Date Received: _____ Date Reviewed: _____

Date Entered: _____ Service Start Date: _____