**Domestic and Family Violence (DFV) | Recognise, Respond & Refer (RRR) Program**

***Hawkesbury and Penrith DFV Linker / Referral Form  
Relationships Australia (RA)***



**This form is to be used by healthcare professionals when referring to the Hawkesbury and   
Penrith DFV Linker for patients who may be affected by domestic and family violence (DFV).**

**Once completed, please send the form via Healthlink secure messaging (EDI: dfvhpran)**

**Or call Jodie on** 0435 753 497

**Referral Date:** Click or tap to enter a date.

## Please indicate if the person is experiencing DFV (and is seeking support) or using DFV (and is seeking behaviour change support)?

## Experiencing DFV: Using DFV:

## Patient / Client Details

## Name: Click or tap here to enter text.

## DOB: Click or tap to enter a date.

## Gender: Choose an item.

## Children’s Details (if applicable):

## Name: Click or tap here to enter text. Age: Click or tap here to enter text. Gender: Choose an item.

## Name: Click or tap here to enter text. Age: Click or tap here to enter text. Gender: Choose an item.

## Address: Click or tap here to enter text.

## Phone: Click or tap here to enter text.

## Email: Click or tap here to enter text.

## Aboriginal and Torres Strait Islander: Choose an item.

## Ethnicity: Click or tap here to enter text.

## Language: Click or tap here to enter text.

## Interpreter required / preferred language: Choose an item. Click or tap here to enter text.

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**Referral Details**

**Reason for referral** (Presenting issues pertaining to domestic and family violence)

Click or tap here to enter text.

**Support required / recommended** (Provide details of what support is required)

Click or tap here to enter text.

**Any other information pertaining to this referral** (optional)

Click or tap here to enter text.

**Safety**

Questions to ask the Patient:

## How safe do you feel at home? (If answered ‘not safe/cannot return home’ follow usual practice procedure) Click or tap here to enter text.

## Is it safe for the DFV Linker to call or email the patient? Choose an item.

## Is it safe for the DFV Linker to leave a message? Choose an item.

## Does the perpetrator live at the same address as person experiencing DFV? Choose an item.

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**Details of Referrer (GP, nurse, allied health, other)**

**Name:** Click or tap here to enter text.

**Position:** Choose an item.

**Practice Name:** Click or tap here to enter text.

**Phone:** Click or tap here to enter text.

**Email:** Click or tap here to enter text.

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**Patient Consent (Patient to complete and sign)**

**I (Patient)** Click or tap here to enter text. **give (Referrer)** Click or tap here to enter text.consent to refer my details to **Relationships Australia – DFV Linker**.By consenting to this referral, I understand that all information in this referral, and any previous referrals (where applicable) including my personal information, will be collected for the primary purpose of delivering services to me. I consent with the understanding that this information will only be used, disclosed and stored for this primary purpose, between the DV Linkers and appropriate referred services.

I understand that de-identified information may also be shared with the Department of Health, and the Nepean Blue Mountains Primary Health Network (NBMPHN) and affiliated partner organisation(s)\*, in accordance with the Australian Government Privacy Act, 1988 for the ongoing monitoring, reporting, evaluation and improvement of services.

*\*Affiliated partner organisation(s) means those required to support the monitoring, reporting, evaluation and/or clinical governance for the service.*

**I also consent to the Referrer (Practice) receiving an update regarding the outcome: Yes  No**

***(Referrer: Please indicate preferred method ­­- phone / email / other)*** Click or tap here to enter text.

**Patient signature / consent:**

***Please allow up to 48 hours (during business hours) for a response.   
If you require assistance out of hours please contact 1800RESPECT or 000 if it is an emergency.***