



Positive Intervention for Children Affected by Domestic Abuse

Referral Date	
Contact Date	
Assessment 1 (date)	
Start date of group	
Follow up (date)	

Checklist:

- Does the family live in RBWM?
 - Are the child/young person and mother in agreement with the referral?
 - Is the child/young person concerned between 8 and 12 years old?
 - Is the mother no longer in the abusive relationship?
 - Does the child/young person have memories of the abuse?
- If any of the above are not ticked the referral cannot proceed**

1. CHILD/YOUNG PERSON'S DETAILS

Name	Male/Female.....
Date of Birth	Age.....
Address	
..... Post code	
School	
Ethnicity	Relationship to alleged abuser.....
Who has parental responsibility?.....	

2. MOTHER'S DETAILS

Name	Age.....
Date of Birth	Age.....
Address (if different to above).....	
..... Post code	
Safe telephone number.....	
Ethnicity	Relationship to alleged abuser.....

3. OTHER CHILDREN IN THE HOUSEHOLD

Surname	First Names	M/F	DOB	Rel'ship to perp

4. OTHER HOUSEHOLD MEMBERS e.g. grandparents/step parent

Surname	First Names	M/F	DOB	Rel'ship to mother/child/young person

5. REASON FOR REFERRAL

Include: family history; history of domestic abuse including whether more than one abusive partner and the relationship(s) of abuser(s) with child(ren); any details re. current risk assessment; impact of the abuse on child/young person (witnessed directly/indirectly) etc:

6. IS THERE ANY CONTACT WITH THE ALLEDGED ABUSER OR ARE THERE ANY COURT ORDERS OR CARE PROCEEDINGS TAKING PLACE?

Yes No

If yes, please give further details:

7. ARE THERE ANY OTHER AGENCIES INVOLVED WITH THE FAMILY? Yes No
If yes, please list who (plus name/tel number of contact)

8. DOES THE CHILD/YOUNG PERSON, OR ANY OTHER CHILDREN IN THE FAMILY HAVE A CHILD PROTECTION PLAN?
Yes No

If yes, please give further details:

9. ARE THERE ANY ISSUES AROUND SUBSTANCE MISUSE OR MENTAL HEALTH FOR EITHER CHILD OR MOTHER?
Yes No

If yes, please give further details:

10. ARE THERE ANY OTHER GROUPS CURRENTLY BEING ATTENDED BY EITHER CHILD/YOUNG PERSON OR MOTHER?
Yes No

If yes, please give further details:

11. ARE THERE ANY OTHER KNOWN SAFETY CONCERNS FOR:
Facilitators visiting the family home? Yes No
Facilitators delivering the group? Yes No
Other children/young people attending the group? Yes No

If yes, please give further details:

12a. ARE THERE ANY TRANSPORT ISSUES THAT NEED TO BE ADDRESSED? Yes No
12b. ARE THERE ANY CHILD CARE ISSUES THAT NEED TO BE ADDRESSED? Yes No

If yes to either of the above, please give further details:

13. PLEASE INDICATE MOTHER'S AVAILABILITY (BOTH DAY AND TIME) FOR ATTENDING PICADA (please tick all preferences)

Monday	Morning	Afternoon
Tuesday	Morning	Afternoon
Wednesday	Morning	Afternoon
Thursday	Morning	Afternoon
Friday	Morning	Afternoon

14. ANY OTHER INFORMATION

Please list any other relevant information that has not already been mentioned:

15. INFORMATION SHARING

I accept the information on this form will be shared with staff/agencies involved in the delivery of PICADA (RBWM), for the purpose of my child participating in the group. I accept that any information disclosed either on this form, or during group, which may put myself and my children at significant risk may be passed to other agencies such as the Police, Berkshire East & South Bucks Women's Aid or Children's Services for action and my safety. The consent is only valid while the child/young person is receiving services from PICADA (RBWM).

Signed _____ (client) Date _____

15. REFERRER DETAILS

Referring Agency
Contact Name
Contact Address
..... Post code
Telephone Number
Email address
Signature Date

Please note making a referral does not guarantee a family's place on the PICADA programme. Places are only allocated after assessment visits have taken place. During the assessment process facilitators will discuss with the family whether or not PICADA is appropriate for them. If PICADA is not assessed as appropriate, alternative sources of support will be explored and referred to.