# REFERRAL FORM – SOAR Service

SOAR is a unique peer-to-peer support service committed to holistically supporting **female survivors** of Intimate Partner Violence (IPV) and their children to rebuild their fractured lives. Our service focuses on female survivors who are no longer at risk of domestic or intimate partner violence.

SOAR is led by female survivors trained locally and in the UK in peer mentoring, risk assessments, and nurturing, loving-kind relationships. It is a one-of-a-kind service that offers an opportunity for survivors of domestic violence to become self-empowered through engagement in formal and non-formal adult education, learning about self-care, advocating to inform policy, influence practices, and reaching out to other survivors. SOAR organises a range of activities through which a community of similarly experienced women thrive, grow in self-compassion and compassion for others, heal and become committed to extending support to others.

**This form has to be sent via email on** [**soar@antidemalta.org**](mailto:soar@antidemalta.org)**.** In case of any queries please call 21808981

# Section A: Details of Referrer and other professionals involved

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Date of Referral:** |  | | **Referring Agency:** | |  | |
| **Service Unit:** |  | | **Profession/ designation:** | |  | |
|  | | | | | | |
| **Name of Referrer:** | |  | | **Warrant No (if applicable):** | |  |
| **Direct Telephone/s Nos:** | |  | | **E-mail address:** | |  |

**Is the survivor still being followed by a social worker from the Domestic Violence Unit?**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Yes |  | No |  |  |

**Details of other Professionals involved with the SURVIVOR being referred**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Name & Surname** | **Designation** | **Organisation** | **Email** | **Tel. No:** | **Comment** |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

**Has a DASH-2019 Checklist Risk Assessment been carried out by the Gender-Based Violence Unit in Floriana in the past three months?**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Yes |  | No |  |  |

**If yes, please specify the outcome:**

|  |
| --- |
|  |

**Do you feel that this survivor is at high risk of experiencing further domestic or intimate partner violence?**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Yes |  | No |  |  |

**IF YES, BEFORE CONTINUING FILLING IN THIS FORM, PLEASE CONTACT THE SOAR SERVICES ON 21808981 TO CONSULT WHETHER THE SERVICE USER SHOULD CARRY OUT A RISK ASSESSMENT.**

**IF NO PLEASE FILL IN THE REMAINING PARTS OF THE REFERRAL FORM TO YOUR BEST KNOWLEDGE.**

# Section B: Survivor Details

**Details of the main person being referred**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Name:** |  | | | **Surname:** |  | | |
| **ID Number:** |  | | | **Date of Birth:** |  | | |
| **Gender:** |  | | | **Nationality:** |  | | |
| **Email address:** |  | | | **Mobile/Telephone number:** |  | | |
| **Address 1:** |  | | | **Address 2 –(locality):** |  | | |
| **Number of adults in need of support (excluding the main person referred)** | **Male** | **Female** | **Other** | **Number of minors in need of support (excluding the main person referred)** | **Male** | **Female** | **Other** |
|  |  |  |  |  |  |
| **Language Preferred:** |  | | | **Citizenship/Immigration status:** |  | | |

**Next of Kin/Emergency Contact:**

|  |  |
| --- | --- |
| **Name and Surname:** |  |
| **Relation:** |  |
| **Contract Details:** |  |

**Status:**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Single |  | Separated | | | | | |
|  | Married |  | Widow/er | | | | | |
|  | Divorced |  | Cohabiting | | | | | |
| **Is the service user referred aware of the referral?** | | | |  | Yes |  | No |  | | Not Yet | |
|  |  |
| **Family Composition and Significant Others (Excluding main person referred):** | | | | | | | | | | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Name & Surname** | **Address** | **Relation** | **Mobile / Telephone** | **ID No:** | **Date of Birth:** | **Comments: (ex employment; relationship, mental health; other)** |
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|  |  |  |  |  |  |  |
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| --- | --- | --- | --- | --- | --- | --- |
| **Is the service user still in contact with the perpetrator?** |  | Yes |  | No |  |  |

If yes, please state the reason why (for example court orders related to children, separation still in process other)

|  |
| --- |
|  |

**Details of the perpetrator (if Available)**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name:** |  | **Surname:** |  |
| **Nationality** |  | **Locality** |  |

# Section C: Presenting Difficulties

**Presenting Difficulties**

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Past Abuse in Intimate Relationship |  | Family Dynamics | | |  | Emotional Distress | |  | |  | |
|  | Caregivers of Mentally Ill Persons |  | Financial Difficulties | | |  | Ill Health and Frailty | |  | |  | |
|  | Homelessness and substandard housing | | |  | Other [please specify] | | |  | |  | |  | |

**Reason for referral according to the referrer:**

(Information re health, support network, practitioners’ comments etc.)

|  |
| --- |
|  |

**Description of survivor’s present situation, including the survivor’s perspective:**

|  |
| --- |
|  |

**Details of any interventions already carried out or still in process:**

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**Other essential information:**

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Signature of Referrer

Date

# Filled-in referral forms are to be forwarded by email on soar@antidemalta.org