DOMESTIC VIOLENCE INTERVENTION PROGRAM
Referral Form

This Referral Form is required to be completed by the Ministry of Children and Family Development (MCFD) personnel and emailed or faxed to the DVIP program at Email: intake.dvip@options.bc.ca or Fax: 604.572.7413.

Referral Date: ________________ Referred by: ____________________ MCFD Office: __________
Phone: ____________________ Fax: ____________ Email: ______________________________

Client Name(s) __________________________ D.O.B.: ___________ ☐ M ☐ F ☐ Other: _______
Address: ____
Home Phone: _____________________________ Okay to leave a message? ☐ Yes ☐ No
Cell Phone: _____________________________ Okay to leave a message? ☐ Yes ☐ No
Preferred Language: _______________________ Other Language(s): ___________________
Special Needs/Disability: ☐ Yes ☐ No ____
Does client identify as Aboriginal? ☐ Yes ☐ No

Marital Status:
☐ Married ☐ Common Law ☐ Separated ☐ Divorced ☐ Single Other: ____________

LEGAL ISSUES

Currently living with partner: ☐ Yes ☐ No ________________________________
Contact order with partner: ☐ Yes ☐ No ________________________________
Access to children: ☐ Yes ☐ No ________________________________
Access to weapons: ☐ Yes ☐ No ________________________________
Criminal History: ☐ Yes ☐ No ________________________________
MCFD supports family unification: ☐ Yes ☐ No ________________________________
Previous counselling/program: ☐ Yes ☐ No ________________________________
Barriers to service: ☐ Child Care ☐ Transportation ☐ Work ☐ Others: ___________

Reason for referral ☐ Partner Abuse ☐ Child Abuse ☐ Other:

Service required ☐ Caring Dad's Group ☐ Individual Counselling

Please attach any relevant information pertaining to this client such as: ☐ Child Protection Report
☐ Mental Health ☐ Alcohol/Drug Abuse ☐ Sexual Abuse ☐ Anger/Violent Behaviour
☐ Employment /Educational Issues ☐ Other: ___________________________

PARTNER'S (Victim's) INFORMATION (☐ Do not contact partner) (☐ Additional information attached)
Client's Name: ________________ D.O.B. _________ ☐ Male ☐ Female ☐ Other: _________
Address: ____
Home Phone: ___________________________ Okay to leave a message? ☐ Yes ☐ No
Cell Phone: ___________________________ Okay to leave a message? ☐ Yes ☐ No
Preferred Language: ____________________ Other Language(s): ___________________
Interpreter Required: ☐ Yes ☐ No Language: ___________________________
Does client identify as Aboriginal? ☐ Yes ☐ No
Is partner receiving services: ☐ SWC ☐ FRAFCA ☐ Delta Assist ☐ ISHTAR ☐ Others: _________
Are children receiving services? ☐ CWWA ☐ School Counsellor ☐ CYMH ☐ Others: _________

All information on this form will be handled in accordance with OCS's confidentiality policies.
If you have any questions about the use of this form, or making a referral, please call the Manager of the DVIP Program at Phone:**604.596.4321**. Cell Phone: **604.809.5742**