DOMESTIC VIOLENCE INTERVENTION PROGRAM
Referral Form

A PROGRAM OF options COMMUNITY SERVICES

Please complete this Referral Form then email to intake.dvip@options.bc.ca or Fax: 604.572.7413.

Referral Date: _____ Referred by: _____ MCFD Office: _____

Phone: _____ Email: _____

Client Name: _____ D.O.B.: _____ ☐ M ☐ F ☐ Other: _____

Phone: _____ Preferred Language: _____

Special Needs/Disability: ☐ Yes ☐ No Specify: _____

Service Required: ☐ Caring Dad's Group ☐ Individual Counselling

Barriers to Service: ☐ Child Care ☐ Transportation ☐ Work ☐ Others: _____

Does client identify as Aboriginal? ☐ Yes ☐ No

Marital Status:

☐ Married ☐ Common Law ☐ Separated ☐ Divorced ☐ Single

Currently living 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 _____

Level of Risk ☐ Low ☐ Medium ☐ High

PLEASE ATTACH DETAILED REPORT FOR HIGH RISK CLIENTS

Presenting Concerns:

☐ Relationship Violence ☐ Others:

☐ Child Abuse

☐ Abusive & Controlling Behaviour

Goals for Counselling:

☐ Complete Caring Dad's group

☐ Others:

PARTNER'S (Victim's) INFORMATION ☐ Do not contact partner ☐ Additional information attached

Name: _____ D.O.B.: _____ ☐ Male ☐ Female ☐ Other:

Phone: _____ Okay to leave a message? ☐ Yes ☐ No

Preferred Language: _____ Interpreter Required: ☐ 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**