DOMESTIC VIOLENCE INTERVENTION PROGRAM
Moms Empowerment Group: Referral Form

A PROGRAM OF options COMMUNITY SERVICES

Please complete this Referral Form then email to intake.dvip@options.bc.ca

Referral Date: _____ Referred by: _____

Phone: _____ Email: _____ MCFD Office/Code: _____

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

Phone: _____ Preferred Language: _____

Client Email: _____

Client Address: Apt.: _____ Street No: _____

City: _____ Postal Code: _____

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

Does client identify as Aboriginal? ☐ Yes ☐ No

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

Children's Information

Name	Age	Requires Childminding During Group
1.		☐
2.		☐
3.		☐

MARITAL STATUS:

☐ Married ☐ Common Law ☐ Separated ☐ Divorced ☐ Single

Currently Living with Partner: ☐ Yes ☐ No _____

Access to Children: ☐ Yes ☐ No _____

Criminal History: ☐ Yes ☐ No _____

MCFD Supports Family Unification: ☐ Yes ☐ No _____

Previous Counselling/Program: ☐ Yes ☐ No _____

Safety Plan in Place: ☐ Yes ☐ No _____

Are there any safety concerns/risks for our staff, clients or their children during the group time, that we should be aware of (i.e. stalking, violating no contact/access orders and threats). ☐ Yes ☐ No

If yes, please specify: _____

PRESENTING CONCERNS:

☐ Victim of Violence ☐ Mental Health Issues ☐ Addiction Issues

☐ Parenting Issues ☐ Other

PARTNER'S (PERPETRATOR'S) INFORMATION

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

Is partner receiving services: ☐ Caring Dad's ☐ RVPP ☐ Anger Management

Are children receiving services? ☐ PEACE ☐ 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 coordinator of the **Mom's Empowerment Group at 604.830.8602**