

**Aviva Sexual Violence Team (SVT)**

**Referral Form**

Please complete this form and forward to svadmin@aviva.org.nz

Details marked with Asterisk (\*) are mandatory to be filled.

|  |  |
| --- | --- |
| Date of Referral\* |  |
| Full Name\* |  |
| Date of Birth\* |  |
| Gender and Preferred Pronouns\* | Choose an item. |
| Ethnicity\* |  |
| Country of Birth\* |  |
| Address\* |  |
| Contact number\* |   |
| Can leave a text\*  |  | Can leave Voicemail\* |  |
| Email |   |
| Preferred method of contact\*  |  |
| Referrer contact details\* (Name, agency, phone and/or email) |  |
|  Offence (if referrer is police) |   |
| Offence date(if referrer is police) |   |
| Brief description of offence(if referrer is police) |   |
| Police File Number(if referrer is police) |   |
| Children |   |
| Brief assessment of needs\* |   |
|  Medical concerns? \* |  |
| Safety concerns? \* |  |
| Risk to Staff? \* |  |
| Permission given for Aviva SVT to contact client. \* |  |