

**Aviva Sexual Violence Team (SVT)**

**Referral Form**

Please complete this form and forward to [svadmin@aviva.org.nz](mailto:sasscadmin@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. \* |  | | | |