

**Aviva Sexual Violence Team (SVT)**

**Referral Form**

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

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

|  |  |
| --- | --- |
| Date of Referral\* | Click or tap here to enter text. |
| Full Name\* |   |
| Date of Birth\* |   |
| Gender and Preferred Pronouns\* | Choose an item. |
| Ethnicity\* |   |
| Country of Birth\* |   |
| Address\* |   |
| Contact number\* |   |
| Can leave a text\*  | Choose an item. | Can leave Voicemail\* | Choose an item. |
| Email |   |
| Preferred method of contact\*  | Choose an item. |
| 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? \* | Click or tap here to enter text. |
| Safety concerns? \* | Click or tap here to enter text. |
| Risk to Staff? \* | Click or tap here to enter text. |
| Permission given for Aviva SVT to contact client? \* | Choose an item. |