**Combatting Human Trafficking and Sexual Exploitation Project**

**&**

**STEP Pilot**

Referral Form – STRICTLY CONFIDENTIAL

Please word process this form and return it to Lizzie Lowenstein

[l.lowenstein@ashianasheffield.org](mailto:l.lowenstein@ashianasheffield.org) │ 07597341436

Date of referral……………………….. Worker taking referral................................

**Referral agency details**

Name…………………………………………………………………..

Job Title ……………..………..……………………………………….

Agency………………….……………………………………………….

Contact details ………………………………………………………..

**CLIENT’S DETAILS**

**Risk Level on Entry: Low / Medium / High *(please circle)* Referred to NRM? Y/N *(please circle)***

|  |  |  |  |
| --- | --- | --- | --- |
| Name |  | DOB  Age |  |
|  |
| Marital Status |  | Contact Telephone Number  Safe to call? Y/N |  |
| Number of dependents  *(see page 3 for full children’s details)* |  | Ethnic Origin  Religion |  |
|  |
| Nationality |  | Immigration Status |  |
| Language Spoken  *(inc dialect)* |  | Level of English  Interpreter needed? Y/N |  |
| Address |  | Safe address? Y/N |  |
| Type of accommodation *(e.g. – NASS, Council, Social Services, staying with friend)* |  |
| Health details  *(inc pregnancy)* |  | Details of any mental health concerns  *(Inc Depression, Anxiety, etc.)* |  |
| Any Disabilities  *(if yes, provide details)* |  | Sexual Orientation  *(Bisexual, Lesbian, Gay, Heterosexual/straight, prefer not to say)* |  |

**Reasons for Referral**

Include details of trafficking and/or NRM history incident, nature of exploitation/abuse

**What support is needed?**

**Safety / Risk**

Is the woman safe remaining in current accommodation Y / N ***(please circle)***

Is she concerned the perpetrator(s) will try and find her? (if yes, please give details)

**Children**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name | F/M | D.O.B | school | Health / medication / allergies / other significant information |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

**Are there any safeguarding concerns? Y / N *(please circle)***

**Has CAF been done? Y / N *(please circle)*  (if yes, please request copy)**

**Perpetrator(s) details**

*Leave blank if unknown / irrelevant (Inc Name, Address, Physical description, and any other relevant information)*

**All agencies involved with Client (IDVAS, GP, Solicitor, HO)**

**Agency Involvement**

**All agencies involved with Woman (inc ISVA, GP, Solicitor, HO)**

|  |  |  |
| --- | --- | --- |
| Agency | Named Worker / Contact no. | Nature of involvement |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**All agencies involved with Children (inc Health Visitor, Teacher, Social Worker)**

|  |  |  |
| --- | --- | --- |
| Agency | Named Worker / Contact no. | Nature of involvement |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

Any other relevant Information

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