



PSI Response Referral Application

Consumer:

Name:

DOB:

Gender:

UR Number:

Client details:

Address:				
Accommodation type:	Public rental	Private rental		
	Family/owned property	Other		
Telephone:				
Email:				
Does the client identify as Aboriginal or Torres Strait Islander:	Aboriginal	Torres Strait Islander	Both	Neither
Ethnicity:				
Does the client have a disability:	Yes	No		
If yes, state nature of disability:				
Does the client have a carer:	Yes	No		
Do children reside in the home:	Yes	No		
If yes, are the risks specific to the children:	Yes	No		
Purpose of PSI response:	Items outside of PSI home audit Home safety and security			
List risks requiring a PSI response:				
Is there an exclusionary IVO:	Yes	No		
If no, why:				

Referring agency information:

Referral date:			
Organisation:			
Case manager:			
Telephone and email:			
Eligibility:	Victim survivor meets PSI eligibility requirements	Yes	No
Consent:	Case manager has ensured victim survivor understands the potential impacts of the PSI response	Yes	No
MARAM:	Risk and Needs Assessment in line with MARAM attached	Yes	No

Consent:

I, _____ (name) by signing the below, agree to:

- give consent to information being shared between professionals (including the PSI Coordinator, Flexible Support Packages (FSP) staff, and security personnel) for the purposes of risk assessment and risk management
- give my consent for the collection of information for the purposes of reporting non-identifying data to funding bodies and gathering statistical information. Additionally, de-identified information may be used for the purposes of evaluation
- give my consent for my information to be securely stored either electronically and/or in hard copy file, which also includes mandated databases provided by funding bodies
- I am aware of and understand the Personal Safety Initiative (PSI) consents and the referral requirements have been discussed with me
- I am aware of and understand the potential impacts and outcomes of a PSI response
- I have been advised I am responsible for any additional expenses/repairs following closure from case management, which includes removal or relocation of CCTV

Completed by:

Worker name:		Position:	
Worker signature:		Date:	
Client signature:		Date:	

Verbal consent:

- should only be used where it is not practicable to obtain written consent from the client.
- I have discussed the PSI referral with the client. I am satisfied my client understands the above consent and has provided informed consent to these

Referrer signature:		Date:	
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Please email completed form to: psi@glch.org.au