



Date: \_\_\_\_\_

Title/Person Completing Referral \_\_\_\_\_

Agency \_\_\_\_\_ Phone Number \_\_\_\_\_

Email Address \_\_\_\_\_ Relationship to client: \_\_\_\_\_

**\*\*Referral Source Release Form Must be completed and submitted with Screening Tool**

**Elder Domestic Violence Shelter Screening Tool**

Client Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

Current Home Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Where is client currently located: \_\_\_\_\_

Safe Number to directly contact client: \_\_\_\_\_

How can we ID when calling: \_\_\_\_\_ Best hours to call: \_\_\_\_\_

Reason for referral: (**Must include medical needs, limitations, safety concerns, abuse history, alternatives that have been exhausted**) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Perpetrator Name: \_\_\_\_\_ Perp Address: \_\_\_\_\_

Relationship of Perpetrator to victim: Married  Yes  No  
Family Member  Yes  No  
If yes, what relationship \_\_\_\_\_  
Living together  Yes  No

Is this the first time they were assaulted by this perpetrator?  Yes  No  
If No, How many times before (estimate #, if not sure) \_\_\_\_\_

Does client need medical attention due to this incident?  Yes  No  
If yes, is client going to ER?  Yes  No If yes, which ER? \_\_\_\_\_

Was the victim sexually assaulted during this incident?  Yes  No  
Has the perpetrator sexually assaulted the victim in the past?  Yes  No

Were the police involved in this incident?  Yes  No

Does client have a current order of protection? Yes No

If yes, which kind? \_\_\_\_\_

Does client wish to obtain an order of protection? Yes No

If yes, which kind? \_\_\_\_\_

Are there children living in the home? Yes No

If yes, does client have custody of the children? Yes No

Name

Age

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Have the children been abused? Yes No

Did the children witness this incident? Yes No

Has CPS been notified of this incident? Yes No

Is there anyone else living in the household? Yes No

If yes, who? \_\_\_\_\_

Are there pets in the home? Yes No

Are there weapons in the house? Yes No

If Yes, what? \_\_\_\_\_

Is there a history of alcohol abuse/substance abuse? Yes No

If yes, is that abuse current? \_\_\_\_\_

Is client currently receiving mental health treatment/services? Yes No

If Yes, please explain: \_\_\_\_\_

Has Protective Services for Adults been contacted? Yes No

Active/Open Case? Yes No

**\*If yes, please complete PSA release form and submit with application**

Has a PRI been completed? Yes No

**\*If yes, please submit with application**