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| **Integrated Victim and Witness Service****Pre-Trial and Outreach Service Referral Form****Defence Witnesses** |  |

**\*\*\*RESTRICTED WHEN COMPLETE\*\*\***

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| **Please enter your name and contact details:** |
| Referral agency |  |
| Referrer’s name |  |
| Role/ Job title |  |
| Contact number  |  |
| Contact email |  |

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| **Trial details & witness contact information:** |
| Regina v.  |  |
| Trial date |  |
| URN |  |
| First name  |  |
| Last name |  |
| DOB |  |
| What do they like to be called |  |
| Current address |  |
| Preferred method of contact | phone [ ]  email [ ]  letter [ ]   |
| Phone number |  | Safe to contact? [ ]   |
| Email address |  | Safe to contact? [ ]   |
| Safe time to contact witness? |  |
| Is witness already being supported by the IWVS or another agency? | Yes [ ]  No [ ]  | Other Agency [ ]  (Please detail) |
| Confirm witness consents to the referral | Yes [ ]  No [ ]  (please note consent must be obtained for onward referral) |

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| **Further information:** |
| Are special measures required? |  |  |
| Yes [ ]  No [ ]   | If yes, please detail: |
| PTV referral only? | Yes [ ]  No [ ]   |
| Has witness been spoken to about process for claiming expenses? | Yes [ ]  No [ ]  |

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| **Accessibility requirements:** |
| Does this witness have any accessibility requirements (for example, hearing loop, braille documents) | Yes [ ]  No [ ]  Don’t know [ ]   | If yes, please provide details: |
| Does this witness require an interpreter? | Yes [ ]  No [ ]  Don’t know [ ]   | If yes, please provide details: |
| **Support needs & additional details:** |
| Please tell us about any support needs the witness may have: |
| Mental health [ ] Physical health [ ]   | Substance misuse [ ]   |
| Additional details for IVWS to note including any concerns witness has about attending court: |
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| **Please email referral to** **IVWS@victimsupport.cjsm.net** |