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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**](mailto:IVWS@victimsupport.cjsm.net) |