



**GBV Administrative Data Toolkit for the Pacific Region**  
**Supporting Resource 2i: TEMPLATE Intake and case assessment long form**

This is a TEMPLATE Intake Form for provision of services and collection of GBV administrative data for female or child clients. Please **change text highlighted in yellow** to reflect your specific organization or context. You may delete this text box and replace logo as needed.

# CONFIDENTIAL

## Intake and case management long form

This form is based on the Kiribati SafeNet Initial Intake and Case Management Form (August 2015) and should be modified for local context.



## INSTRUCTIONS

1. This form should be filled out by a [organisation name] staff member (case manager, health practitioner, social worker or other authorised person providing services to the client victim of gender-based violence). Complete all pages each time a client is referred to your organisation for gender-based violence. That is, if the same client is referred more than once on different dates, please record the information for each referral on separate intake forms. This way we can record information about separate incidents of violence.
2. **Remind the client that all information will be kept confidential, and they may choose not to answer any of the following questions.**
3. Ask the client for their consent to use **non-identifiable** information for planning service delivery for victims of violence. This form should be accompanied by a separate consent form for release of information, and the check box ticked at the end of this form.
4. Complete this intake form for all incidents of GBV.
5. Enter data from this form into [organisation name database] when available.
6. Write as much information as you feel is necessary (additional pages with continued narrative may be attached if needed).
7. If the client consents to their information being shared, follow [organisation name]'s Information Sharing Protocol.

**IMPORTANT:** Whenever possible, questions with an asterisk \* should always be answered. These questions are part of a minimum essential dataset on gender-based violence.

CLIENT CODE

## INTAKE AND CASE MANAGEMENT LONG FORM

INCIDENT ID

CONFIDENTIAL

### SECTIONS FOR COMPLETION

- |                                    |  |
|------------------------------------|--|
| 1. ADMINISTRATIVE INFORMATION      | 5. PLANNED ACTION / ACTION TAKEN REGARDING THIS REPORT |
| 2. CLIENT INFORMATION              | 6. ASSESSMENT POINTS                                   |
| 3. DETAILS OF THE INCIDENT         | 7. OVERALL CLIENT SAFETY                               |
| 4. ALLEGED PERPETRATOR INFORMATION |  |

### 1 ADMINISTRATIVE INFORMATION

*Client name:	*Staff name/code:	*Report by client? <input type="checkbox"/> Yes <input type="checkbox"/> No
*Report/interview date (day/month/year):	*Incident date (day/month/year). If there are multiple times write the most recent:	
*Who is reporting this violence?		
<input type="checkbox"/> The client		
<input type="checkbox"/> A family member or friend but the client is here <input type="checkbox"/> A family member or friend and the client is NOT here		
<input type="checkbox"/> A counsellor but the client is here <input type="checkbox"/> A counsellor but the client is NOT here		
<input type="checkbox"/> An elder or church leader but the client is here <input type="checkbox"/> An elder or church leader but the client is NOT here		
<input type="checkbox"/> Other (specify):		

<b>2 CLIENT INFORMATION</b>		
<b>*Client age in years:</b>	<b>*Sex of client:</b> <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Other	<b>Primary language:</b>
<b>*Specific needs/vulnerabilities of client (check <u>all</u> that apply):</b> <input type="checkbox"/> None <input type="checkbox"/> Unknown <input type="checkbox"/> Physical disability <input type="checkbox"/> Mental disability <input type="checkbox"/> Unaccompanied minor <input type="checkbox"/> Separated child <input type="checkbox"/> Other vulnerable child <input type="checkbox"/> [Other]		<b>*Client's country/island of origin (or replace with other items):</b> <input type="checkbox"/> [Country A] <input type="checkbox"/> [Country B] <input type="checkbox"/> [Country C] <input type="checkbox"/> Other (specify):
<b>*Difficulties with certain activities (please select one option for each question below):</b>		
1. Does the client have difficulty <b>seeing</b> , even if wearing glasses?	<input type="checkbox"/> No difficulty	<input type="checkbox"/> Some difficulty
2. Does the client have difficulty <b>hearing</b> , even if using a hearing aid(s)?	<input type="checkbox"/> No difficulty	<input type="checkbox"/> Some difficulty
3. Does the client have <b>difficult walking or climbing steps</b> ?	<input type="checkbox"/> No difficulty	<input type="checkbox"/> Some difficulty
4. Does the client have difficulty <b>remembering or concentrating</b> ?	<input type="checkbox"/> No difficulty	<input type="checkbox"/> Some difficulty
5. Does the client have difficulty with <b>self-care</b> , such as washing all over or dressing?	<input type="checkbox"/> No difficulty	<input type="checkbox"/> Some difficulty
6. With their usual language, does the client have difficulty <b>communicating</b> , for example <b>understanding or being understood</b> ?	<input type="checkbox"/> No difficulty	<input type="checkbox"/> Some difficulty
<b>*Current marital status:</b> <input type="checkbox"/> Single <input type="checkbox"/> Married/Cohabiting <input type="checkbox"/> Divorced/Separated <input type="checkbox"/> Widowed		<b>Religion:</b>
<b>*Is the client looking after anyone else?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Who else is the client looking after?</b>	<b>Is the client working outside of the home:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>*How many children does the client look after?</b>	<b>*How old is the youngest child?</b>	<b>*How old is the oldest child?</b>
<b>*Is the client pregnant?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		<b>*Does the client have a new baby?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>*Is the client a child living separately from parents?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>Has the client been depressed or diagnosed with a mental health issue?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
<b>Any other client information:</b>		
<i>Sub-section for child clients (less than 18 years old)</i>		
<b>*Child age in years:</b>	<b>*If the client is a child (less than 18 years) do they live alone?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No (If 'No', answer the next two questions)	
<b>*If the child client lives with someone, what is the relation between them and the caretaker?</b> <input type="checkbox"/> Parent/Guardian <input type="checkbox"/> Relative <input type="checkbox"/> Spouse/Cohabiting <input type="checkbox"/> Other (specify):		
<b>*What is the caretaker's current marital status?</b> <input type="checkbox"/> Single <input type="checkbox"/> Married/Cohabiting <input type="checkbox"/> Divorced/Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Unknown/Not applicable		
<b>Any other child client information:</b>		

### 3 DETAILS OF THE INCIDENT

**Incident location (detailed):**  Client's home  Perpetrator's home  
 Outdoor setting (e.g., market)  School  Church  Near public toilet  
 Boat  Car  Public transport  Road  
 Other (please give details):

**\*Time incident took place:**  
 Morning (sunrise to noon)  
 Afternoon (noon to sunset)  
 Evening/night (sunset to sunrise)  
 Unknown/Not applicable

**\*Village/area of island the incident occurred:**

**\*Area/island where the incident occurred:**

**\*Account of the incident/Description of the incident (summarise the details of the incident and use the client's words):**

**\*Did the perpetrator force the client to live somewhere they didn't want to live?**  Yes  No

If yes, please provide information about this to explain:

**\*Where is the perpetrator now?**  At home  Unknown  Working  Staying away with other family or friends  
 With police  Other (specify):

**\*Type of incident/violence** (Please select ONLY ONE of the options below).

- Rape** (includes gang rape, marital rape)
- Sexual assault** (includes attempted rape and all sexual violence/abuse without penetration, and female genital mutilation)
- Physical assault** (includes hitting, slapping, kicking, shoving, etc, that are not sexual in nature)
- Forced marriage** (includes early marriage)
- Denial of resources, opportunities, or services** (includes denial of inheritance, earnings, access to education or contraceptives, etc. Reports of general poverty do not apply)
- Psychological/Emotional abuse** (includes threats of physical or sexual violence, forced isolation, harassment/intimidation, gestures or written words of a sexual/menacing nature, etc.)
- Non-GBV** (specify):

**Questions to determine type of incident/violence**

- 1. Did the reported incident involve penetration?**  
 If yes → classify the incident as '**Rape**'.  
 If no → proceed to the next incident type on the list.
- 2. Did the reported incident involved unwanted sexual contact?**  
 If yes → classify the incident as '**Sexual assault**'.  
 If no → proceed to the next incident type on the list.
- 3. Did the reported incident involve physical assault?**  
 If yes → classify the incident as '**Physical assault**'.  
 If no → proceed to the next incident type on the list.
- 4. Was the incident an act of forced marriage?**  
 If yes → classify the incident as '**Forced marriage**'.  
 If no → proceed to the next incident type on the list.
- 5. Did the reported incident involve the denial of resources, opportunities or services?**  
 If yes → classify the incident as '**Denial of resources, opportunities or services**'.  
 If no → proceed to the next incident type on the list.
- 6. Did the reported incident involve psychological/emotional abuse?**  
 If yes → classify the incident as '**Psychological/Emotional abuse**'.  
 If no → proceed to the next incident type on the list.
- 7. Is the reported incident a case of GBV?**  
 If yes → Restart at 1 and try to classify the incident. If you have tried to classify the incident multiple times, ask your supervisor for assistance.  
 If no → classify the incident as '**Non-GBV**'.

**Details of the type of incident/violence** (please select any that apply):

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Slapped or threw something<br><input type="checkbox"/> Pushed or shoved<br><input type="checkbox"/> Hit with fist or something else<br><input type="checkbox"/> Kicked or dragged<br><input type="checkbox"/> Choked<br><input type="checkbox"/> Burned<br><input type="checkbox"/> Threatened the client with a weapon | <input type="checkbox"/> Threatened to kill the client<br><input type="checkbox"/> Threatened to hurt another family member<br><input type="checkbox"/> Threatened to kill another family member<br><input type="checkbox"/> Threatened to hurt/kill a pet or animal<br><input type="checkbox"/> Physically forced sexual intercourse<br><input type="checkbox"/> Had sexual intercourse because was afraid | <input type="checkbox"/> Forced to do something sexually degrading<br><input type="checkbox"/> Psychological or emotional abuse (like calling names or criticising what the client does)<br><input type="checkbox"/> Denial of opportunities or services (like education, medicine or opportunity to work)<br><input type="checkbox"/> Denial of resources like money |
|--|---|---|

### 3 DETAILS OF THE INCIDENT (continued)

Did the client sustain injuries during the incident?  No  
 Yes (please specify):

\*Did the client die as a result of injuries?  Yes  No

\*Were weapons involved?  Yes  No

\*What type of weapons were involved?

\*Was the client forced to do something where people paid money for it?  Yes  No

\*Was this incident a Harmful Traditional Practice?  
 No  [Practice 1]  [Practice 2]  [Practice 3]

\*Were money, goods, benefits, and/or services exchanged in relation to this incident?  Yes  No

\*Has the client reported the incident anywhere else? (If yes, specify the type of service(s))  No  Yes (specify below)

- Health/medical services       Police/other security service       Other (specify):  
 Counselling services       Legal assistance services  
 Community organisation       Crisis/safe house/shelter

\*Has the client had any previous incidents of GBV perpetrated against them?

No  Unknown  Yes (please provide a brief description):

#### 4 ALLEGED PERPETRATOR INFORMATION

\*Number of alleged perpetrators:  1  2  3  More than 3  Unknown

If more than 1 perpetrator, please provide an explanation of the situation. If only 1 perpetrator, you may leave this blank.

Have any of the alleged perpetrators ever had any court orders or bail conditions?  No  Yes  Unknown

If YES, are they currently under any court orders or bail conditions?  No  Yes  Unknown

If YES, have they ever violated the court order or bail condition?  No  Yes  Unknown

*Please complete the following questions for the alleged perpetrator (perpetrator 1).*

*If more than 1 alleged perpetrator, complete SECTION 4B at the end of this form for each additional alleged perpetrator.*

\*Sex of alleged perpetrator:  Female  Male  Other

\*Alleged perpetrator age:  Adult  Minor  Unknown

\*Home/place of origin of alleged perpetrator (if known):

\*Alleged perpetrator relationship with client:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Current husband / wife / boyfriend / girlfriend / de facto          | <input type="checkbox"/> Aunt             | <input type="checkbox"/> Religious leader          |
| <input type="checkbox"/> Former husband / wife / boyfriend / girlfriend / de facto           | <input type="checkbox"/> Uncle            | <input type="checkbox"/> Police officer            |
| <input type="checkbox"/> Mother / stepmother / adoptive mother                               | <input type="checkbox"/> Sibling          | <input type="checkbox"/> Work colleague            |
| <input type="checkbox"/> Father / stepfather / adoptive father                               | <input type="checkbox"/> Adopted sibling  | <input type="checkbox"/> Teacher / School official |
| <input type="checkbox"/> Grandparent   | <input type="checkbox"/> Community leader | <input type="checkbox"/> Schoolmate                |
| <input type="checkbox"/> Family friend / neighbour <input type="checkbox"/> Service provider | <input type="checkbox"/> No relation      | <input type="checkbox"/> Other (specify):          |
| <input type="checkbox"/> Other community member <input type="checkbox"/> Housemate           | <input type="checkbox"/> Unknown          |  |

\*Main occupation of alleged perpetrator:  [Occupation 1]  [Occupation 2]  Other/Unknown  Unemployed

\*Does the alleged perpetrator have difficulties with certain activities (please select one option for each question below):

1. Does the client have difficulty **seeing**, even if wearing glasses?  No difficulty  Some difficulty  A lot of difficulty  Cannot do at all
2. Does the client have difficulty **hearing**, even if using a hearing aid(s)?  No difficulty  Some difficulty  A lot of difficulty  Cannot do at all
3. Does the client have **difficult walking or climbing steps**?  No difficulty  Some difficulty  A lot of difficulty  Cannot do at all
4. Does the client have difficulty **remembering or concentrating**?  No difficulty  Some difficulty  A lot of difficulty  Cannot do at all
5. Does the client have difficulty with **self-care**, such as washing all over or dressing?  No difficulty  Some difficulty  A lot of difficulty  Cannot do at all
6. Using their usual language, does the client have difficulty **communicating**, for example **understanding or being understood**?  No difficulty  Some difficulty  A lot of difficulty  Cannot do at all

Any other information relating to this alleged perpetrator:

## 5 PLANNED ACTION / ACTION TAKEN REGARDING THIS REPORT

**\*Who referred this client to you:**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Health / Medical services     | <input type="checkbox"/> Police / Other security actor       | <input type="checkbox"/> Other government service |
| <input type="checkbox"/> Community leader              | <input type="checkbox"/> Psychosocial / Counselling services | <input type="checkbox"/> Self-referred            |
| <input type="checkbox"/> Teacher / School official     | <input type="checkbox"/> Legal services                      | <input type="checkbox"/> Other (specify):         |
| <input type="checkbox"/> Safe house / shelter / refuge | <input type="checkbox"/> Livelihood program                  |   |

**\*Was the client referred to a safehouse / shelter?**

- Yes       No – Service provided by you  
 No – Service received prior to this visit  
 No – Service not applicable  
 No – Referral declined by survivor  
 No – Service unavailable

**\*Was the client referred to a health / medical?**

- Yes       No – Service provided by you  
 No – Service received prior to this visit  
 No – Service not applicable  
 No – Referral declined by survivor  
 No – Service unavailable

**\*Was the client referred to a psychosocial service?**

- Yes       No – Service provided by you  
 No – Service received prior to this visit  
 No – Service not applicable  
 No – Referral declined by survivor  
 No – Service unavailable

**\*Was the client referred to a legal service?**

- Yes       No – Service provided by you  
 No – Service received prior to this visit  
 No – Service not applicable  
 No – Referral declined by survivor  
 No – Service unavailable

**Does the client want to pursue legal action?**    Yes    No    Undecided at time of report

**\*Was the client referred to the police or other type of security actor?**

- Yes       No – Service provided by you  
 No – Service received prior to this visit  
 No – Service not applicable  
 No – Referral declined by survivor  
 No – Service unavailable

**\*Was the client referred to an NGO / community program?**

- Yes       No – Service provided by you  
 No – Service received prior to this visit  
 No – Service not applicable  
 No – Referral declined by survivor  
 No – Service unavailable

**Any other planned action/actions taken:**

## 6 ASSESSMENT POINTS

**Describe the client's emotional state at the beginning of the interview:**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Scared / Fearful | <input type="checkbox"/> Anxious / Nervous | <input type="checkbox"/> Calm             |
| <input type="checkbox"/> Sad / Depressed  | <input type="checkbox"/> Angry             | <input type="checkbox"/> Other (specify): |

**Describe the client's emotional state at the end of the interview:**

- |  |  |
|--|--|
| <input type="checkbox"/> Calmer than at the beginning of the interview | <input type="checkbox"/> More upset than at the start of the interview |
| <input type="checkbox"/> Similar to that at the start of the interview | <input type="checkbox"/> Other (specify):                              |

**Will the client be safe when they leave?**

- Yes  Unknown  
 No → Why not?

**What actions were taken to ensure the client's safety?**

- |  |  |
|--|--|
| <input type="checkbox"/> Safety plan created           | <input type="checkbox"/> Service provider to follow up       |
| <input type="checkbox"/> Referral to safe house        | <input type="checkbox"/> Referral to community-based support |
| <input type="checkbox"/> Other action taken (specify): |  |

**If raped, have you explained possible consequences of rape to the client?**

- Yes  No  Not applicable

**Have you explained the possible consequences of rape to the client's caregiver (if the client is under the age of 14)?**

- Yes  No  Not applicable

*Ask the client if they will give consent for their non-identifiable information to be shared for planning resources and service delivery for victims of violence. No identifying information such as names will be shared.*

**\*Did the client give their consent to share their non-identifiable information for reporting purposes?**

- Yes  No

## 7 OVERALL CLIENT SAFETY

**\*Is the perpetrator of abuse with the client now?**  Yes  No  Unknown

**\*Is the client afraid of the perpetrator?**  Yes  No  Unknown

**\*Is the client afraid to go home?**  Yes  No  Unknown

**\*Has physical violence increased in severity or frequency?**  Yes  No  Unknown

**\*Has the perpetrator ever physically abused children?**  Yes  No  Unknown

**\*Has the perpetrator ever sexually abused children?**  Yes  No  Unknown

**\*Have children ever witnessed violence in the home?**  Yes  No  Unknown

**\*Is there a weapon in the home?**  Yes  No  Unknown

**\*Has the perpetrator ever threatened to kill someone?**  Yes  No  Unknown

**\*Has the client ever spoken about or attempted suicide?**  Yes  No  Unknown

**Have there ever been threats of suicide by the perpetrator?**  Yes  No  Unknown

**\*Is there alcohol or substance abuse by the client?**  Yes  No  Unknown

**Is there alcohol or substance abuse by the perpetrator?**  Yes  No  Unknown

**Any other client safety information:**



## REMINDER

1. If more than 1 alleged perpetrator, please complete SECTION 4B (below).  
If there are no additional perpetrators, you may leave SECTION 4B blank.
2. Enter data from this form into [organisation name database] when finalised.
3. If the client has consented to their information being shared, follow [organisation name]'s Information Sharing Protocol.

Please complete the following questions for each alleged perpetrator additional to perpetrator 1 described in SECTION 4.

## 4B INFORMATION FOR ADDITIONAL ALLEGED PERPETRATORS

### (Perpetrator 2)

\*Sex of alleged perpetrator:  Female  Male  Other      \*Alleged perpetrator age:  Adult  Minor  Unknown

\*Home/place of origin of alleged perpetrator (if known):

\*Alleged perpetrator relationship with client:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Current husband / wife / boyfriend / girlfriend / de facto          | <input type="checkbox"/> Aunt             | <input type="checkbox"/> Religious leader          |
| <input type="checkbox"/> Former husband / wife / boyfriend / girlfriend / de facto           | <input type="checkbox"/> Uncle            | <input type="checkbox"/> Police officer            |
| <input type="checkbox"/> Mother / stepmother / adoptive mother                               | <input type="checkbox"/> Sibling          | <input type="checkbox"/> Work colleague            |
| <input type="checkbox"/> Father / stepfather / adoptive father                               | <input type="checkbox"/> Adopted sibling  | <input type="checkbox"/> Teacher / School official |
| <input type="checkbox"/> Grandparent   | <input type="checkbox"/> Community leader | <input type="checkbox"/> Schoolmate                |
| <input type="checkbox"/> Family friend / neighbour <input type="checkbox"/> Service provider | <input type="checkbox"/> No relation      | <input type="checkbox"/> Other (specify):          |
| <input type="checkbox"/> Other community member <input type="checkbox"/> Housemate           | <input type="checkbox"/> Unknown          |  |

\*Main occupation of alleged perpetrator:  [Occupation 1]  [Occupation 2]  Other/Unknown  Unemployed

\*Does the alleged perpetrator have difficulties with certain activities (please select one option for each question below):

1. Does the client have difficulty **seeing**, even if wearing glasses?       No difficulty     Some difficulty     A lot of difficulty     Cannot do at all
2. Does the client have difficulty **hearing**, even if using a hearing aid(s)?       No difficulty     Some difficulty     A lot of difficulty     Cannot do at all
3. Does the client have **difficult walking or climbing steps**?       No difficulty     Some difficulty     A lot of difficulty     Cannot do at all
4. Does the client have difficulty **remembering or concentrating**?       No difficulty     Some difficulty     A lot of difficulty     Cannot do at all
5. Does the client have difficulty with **self-care**, such as washing all over or dressing?       No difficulty     Some difficulty     A lot of difficulty     Cannot do at all
6. Using their usual language, does the client have difficulty **communicating**, for example **understanding or being understood**?       No difficulty     Some difficulty     A lot of difficulty     Cannot do at all

Any other information relating to this alleged perpetrator:

**4B INFORMATION FOR ADDITIONAL ALLEGED PERPETRATORS (continued)**  
**(Perpetrator 3)**

\*Sex of alleged perpetrator:  Female  Male  Other      \*Alleged perpetrator age:  Adult  Minor  Unknown

\*Home/place of origin of alleged perpetrator (if known):

\*Alleged perpetrator relationship with client:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Current husband / wife / boyfriend / girlfriend / de facto          | <input type="checkbox"/> Aunt             | <input type="checkbox"/> Religious leader          |
| <input type="checkbox"/> Former husband / wife / boyfriend / girlfriend / de facto           | <input type="checkbox"/> Uncle            | <input type="checkbox"/> Police officer            |
| <input type="checkbox"/> Mother / stepmother / adoptive mother                               | <input type="checkbox"/> Sibling          | <input type="checkbox"/> Work colleague            |
| <input type="checkbox"/> Father / stepfather / adoptive father                               | <input type="checkbox"/> Adopted sibling  | <input type="checkbox"/> Teacher / School official |
| <input type="checkbox"/> Grandparent   | <input type="checkbox"/> Community leader | <input type="checkbox"/> Schoolmate                |
| <input type="checkbox"/> Family friend / neighbour <input type="checkbox"/> Service provider | <input type="checkbox"/> No relation      | <input type="checkbox"/> Other (specify):          |
| <input type="checkbox"/> Other community member <input type="checkbox"/> Housemate           | <input type="checkbox"/> Unknown          |  |

\*Main occupation of alleged perpetrator:  [Occupation 1]  [Occupation 2]  Other/Unknown  Unemployed

\*Does the alleged perpetrator have difficulties with certain activities (please select one option for each question below):

- Does the client have difficulty **seeing**, even if wearing glasses?       No difficulty     Some difficulty     A lot of difficulty     Cannot do at all
- Does the client have difficulty **hearing**, even if using a hearing aid(s)?       No difficulty     Some difficulty     A lot of difficulty     Cannot do at all
- Does the client have **difficult walking or climbing steps**?       No difficulty     Some difficulty     A lot of difficulty     Cannot do at all
- Does the client have difficulty **remembering or concentrating**?       No difficulty     Some difficulty     A lot of difficulty     Cannot do at all
- Does the client have difficulty with **self-care**, such as washing all over or dressing?       No difficulty     Some difficulty     A lot of difficulty     Cannot do at all
- Using their usual language, does the client have difficulty **communicating**, for example **understanding or being understood**?       No difficulty     Some difficulty     A lot of difficulty     Cannot do at all

Any other information relating to this alleged perpetrator:

**4B INFORMATION FOR ADDITIONAL ALLEGED PERPETRATORS (continued)**

**(Perpetrator 4)**

\*Sex of alleged perpetrator:  Female  Male  Other

\*Alleged perpetrator age:  Adult  Minor  Unknown

\*Home/place of origin of alleged perpetrator (if known):

\*Alleged perpetrator relationship with client:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Current husband / wife / boyfriend / girlfriend / de facto          | <input type="checkbox"/> Aunt             | <input type="checkbox"/> Religious leader          |
| <input type="checkbox"/> Former husband / wife / boyfriend / girlfriend / de facto           | <input type="checkbox"/> Uncle            | <input type="checkbox"/> Police officer            |
| <input type="checkbox"/> Mother / stepmother / adoptive mother                               | <input type="checkbox"/> Sibling          | <input type="checkbox"/> Work colleague            |
| <input type="checkbox"/> Father / stepfather / adoptive father                               | <input type="checkbox"/> Adopted sibling  | <input type="checkbox"/> Teacher / School official |
| <input type="checkbox"/> Grandparent   | <input type="checkbox"/> Community leader | <input type="checkbox"/> Schoolmate                |
| <input type="checkbox"/> Family friend / neighbour <input type="checkbox"/> Service provider | <input type="checkbox"/> No relation      | <input type="checkbox"/> Other (specify):          |
| <input type="checkbox"/> Other community member <input type="checkbox"/> Housemate           | <input type="checkbox"/> Unknown          |  |

\*Main occupation of alleged perpetrator:  [Occupation 1]  [Occupation 2]  Other/Unknown  Unemployed

\*Does the alleged perpetrator have difficulties with certain activities (please select one option for each question below):

1. Does the client have difficulty **seeing**, even if wearing glasses?  No difficulty  Some difficulty  A lot of difficulty  Cannot do at all
2. Does the client have difficulty **hearing**, even if using a hearing aid(s)?  No difficulty  Some difficulty  A lot of difficulty  Cannot do at all
3. Does the client have **difficult walking or climbing steps**?  No difficulty  Some difficulty  A lot of difficulty  Cannot do at all
4. Does the client have difficulty **remembering or concentrating**?  No difficulty  Some difficulty  A lot of difficulty  Cannot do at all
5. Does the client have difficulty with **self-care**, such as washing all over or dressing?  No difficulty  Some difficulty  A lot of difficulty  Cannot do at all
6. Using their usual language, does the client have difficulty **communicating**, for example **understanding or being understood**?  No difficulty  Some difficulty  A lot of difficulty  Cannot do at all

Any other information relating to this alleged perpetrator: