Referral Form

Please complete in full using block letters

Details of person being referred:		How did you hear about CCC or who referred you:
Mrs Ms Miss *(delete as appropriate – females only)*		**Name:**
Surname:		**Job Title:**
First Name:		**Organisation:**
Date of Birth:	**Age:**	**Contact No:**
Address:		Details of GP ***(unless already given above)***
		GP Name:
Postcode:		**Surgery Name:**
Ok to send mail to this address? *(Delete one)* **Yes No**		Please tell us about any mental health problems or give a brief reason for referral
Landline No:		
Ok to leave messages on landline? *(Delete one)* **Yes No**		
Mobile No:		
Ok to text/leave messages on mobile? *(Delete one)* **Yes No**		

Email Contact & Permissions:	
Email Address:	
Ok to contact by email? *(delete one)* **Yes No**	**Ok to send updates about CCC by email?** *(delete one)* **Yes No**
Ok to send occasional surveys or opinion polls about CCC by email? *(delete one)* **Yes No**	

Please tick below all services to access:
NB: All new referrals must attend an Assessment before accessing any services. Minimum age 18. No childcare provision

Service		Service	
Counselling *(one-to-one)*		**Empowered Women** *(domestic abuse)*	
Brave Women *(anxiety management)*		**Journey Through Grief** *(bereavement)*	
Confident Women *(confidence/assertion)*		**Supported Women** *(mental health support)*	
Creative Women *(arts & crafts)*		**Uplifted Women** *(managing depression)*	
***NEW* COVID-19 Key Carer Support Group**		***NEW* COVID-19 Bereavement Support Group**	

Form Completed By:		Date:	

Please return to: Chrysalis Centre for Change (CCC), Email: **chrysaliscentreforchange@gmail.com**
Post: **1st Floor, The Beacon Building, YMCA, 25 College Street, St Helens WA10 1TF**

CCC OFFICE USE ONLY: Referral taken/received by: (*circle one*) Post Email Phone In Person			
Date/Time of Assessment:		Date Added to Waiting Lists:	