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| *Please complete in full using block letters* |

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| **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** |

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| **Email Contact & Permissions: (Info not required for referral - can be completed during assessment by CCC)** |
| **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** |

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| **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)* |  | **Creative Women** *(arts & crafts)* |  |
| **CBT Therapy** *(one-to-one)* |  | **Empowered Women** *(domestic abuse)* |  |
| **1-2-1 Phone Support Sessions** |  | **Journey Through Grief** *(bereavement)* |  |
| **Brave Women** *(anxiety management)* |  | **Supported Women** *(mental health support)* |  |
| **Confident Women** *(confidence/assertion)* |  | **Uplifted Women** *(managing depression)* |  |

**As a Charity, we rely entirely on external funding and donations to offer you these services. So, we ask for a minimum donation of £1 per session for every service, to help us to continue running. Thank you for your understanding.**

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| **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** |

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