Chrysalis Centre *for* Change
Supporting
Empowering
Inspiring
women to reach their full potential

Client Information

Details of person being referred:	
Surname:	
First Name:	
Date of Birth:	**Age:**
Address (please include postcode):	
Can we send post to this address? **Yes** ☐ **No** ☐	
Mobile No: **Landline number (if no mobile):**	
Can we phone you on above number/s? **Yes** ☐ **No** ☐	
Can we send texts to above number? **Yes** ☐ **No** ☐	
Can we leave voicemails on above number/s? **Yes** ☐ **No** ☐	

How did you hear about CCC / Referrer details:
Name:
Job Title:
Organisation:
Contact No:
Details of GP *(unless already given above)*
Named GP:
Surgery Name:
Please BRIEFLY give the MAIN reason for referral (e.g. domestic abuse)

Email Contact & Permissions:	
Email Address of person being referred:	
Can we contact you by email? Yes ☐ **No** ☐	**Can we send updates about CCC by email? Yes** ☐ **No** ☐
Can we send occasional surveys or opinion polls about CCC by email? Yes ☐ **No** ☐	

Health Information:	
Please tell us about any illnesses or conditions including: • **mental health problems** • **physical disabilities** • **asthma** • **epilepsy** • **hearing/visual impairments** • **learning difficulties**	
Do you need any adjustments to access our services?	
Please list any prescribed medication	
Who can we contact in an Emergency? ***Please give:*** • *Their name;* • *Their contact number* • *Their relationship to you*	

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Services Information:

Are you or have you been involved with any other services, e.g., Social Services, Home Treatment Team, Jobcentre, Carers Centre?			
Date of MARAC (if applicable)		Pending or current court case?	Yes ☐ No ☐
Can we share information about your engagement with CCC with other organisations you are involved with, including your GP?			Yes ☐ No ☐

What would you like to gain from accessing CCC services? E.g., confidence, help for anxiety

Please tick below all services you wish to access

NB: All new referrals must attend an Assessment before accessing any services. Minimum age 18. No childcare provision

One-to-One Support	TICK BELOW	Therapeutic Groups	TICK BELOW
Counselling / CBT	☐	Creative Women *(arts & crafts)*	☐
		Wellbeing Workshops *(various topics)*	☐
Personal Development Courses	**TICK BELOW**	**Support Groups**	**TICK BELOW**
Brave Women *(anxiety management)*	☐	Empowered Women *(domestic abuse)*	☐
Confident Women *(confidence/assertion)*	☐	Supported Women *(mental health support)*	☐
Uplifted Women *(managing depression)*	☐	Journey Through Grief *(bereavement)*	☐

As a Charity, we rely entirely on 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.

Preference for counselling / CBT: (F2F / Phone / Zoom):

Availability for counselling / CBT: (days / times)

OPTIONAL SECTION:

Are you happy to answer some Equalities information? This is only ever reported ANONYMOUSLY

Your Ethnicity	Do not wish to disclose	Your marital status	Do not wish to disclose
Are you Disabled?	Do not wish to disclose	Culture, Belief, Religion	Do not wish to disclose
Your sexual orientation	Do not wish to disclose	Gender Identity	Do not wish to disclose
Have you ever identified as transgender?	Do not wish to disclose		

Confirmation:

By signing below I understand and agree that the information on this form is correct to the best of my knowledge.

Your Signature: Date:

Referral Date:		Referral Route: (online / email / phone)	
Assessment Type:		Assessment Date:	