Referral Information Form

Chrysalis Centre for Change

(Please complete in full using block letters)

Service User Details		Tell us how you heard about CCC /who referred you
Mrs Ms Miss (female service only)		Name:
Surname:		Professional Title:
First Name:		Organisation:
Date Of Birth:	Age:	Telephone:
Address:		GP Name: (if not referrer)
		Surgery Name:
Postcode:		Can we share information with your GP about your engagement with CCC? Yes ❑ No ❑
Can we contact client by mail at this address? Yes ❑ No ❑		Please identify any diagnosed mental health problems:
Landline Number: Can CCC leave messages at this number? Yes ❑ No ❑		
Mobile Number: Can CCC leave messages/texts at this number? Yes ❑ No ❑		

Do you require downstairs appointments due to mobility issues? Yes ❑ No ❑

Please tell us which services you wish to refer to/access: *Please tick all that apply*
NB: All new referrals must attend an Assessment before accessing any services. Minimum age 18. No childcare provision available

Service	Wishes to Access	Added to Waiting List
Counselling		
Confidence & Assertion Course		
A Journey Through Grief *(Bereavement Programme)*		
Therapeutic Art & Craft Sessions		*Not applicable*

Service	Wishes to Access	Added to waiting list
Positive Me Programme *(CBT)*		
Stress Management Course		
Domestic Abuse Support *(Emotional support only)*		*Not applicable*

Referral Information Form Completed By:	Date:
Please return form to: Chrysalis Centre for Change, Peter Street Community Centre, Peter Street, St. Helens WA10 2EQ or email to address below	

CCC OFFICE USE ONLY: Referral taken/received by Post ❑ Email ❑ Phone ❑ In person ❑

Date/Time of Assessment Appointment: