



Central West Women's Health Centre Inc.

**REFERRAL TO CHILD & ADOLESCENT SEXUAL
ASSAULT COUNSELLING SERVICE**

Referral Date:

Client's Details
Name:
Date of Birth:
Address:
Parent/carer contact person:
Home Phone:
Mobile Phone:

Person Making Referral
Name:
Position:
Organisation:
Contact Number:

Reason for Referral
Counselling <input type="checkbox"/> Protective Behaviours <input type="checkbox"/> Court Preparation <input type="checkbox"/> Other <input type="checkbox"/>
Please describe:

20 William Street * PO Box 674 * Bathurst NSW 2795
Phone: 02 6331 4133 * Fax: 02 6332 4310 * Email: csa@cwwhc.org.au website: www.cwwhc.org.au

Funded by NSW Department of Human Services (Community Services)
ABN 28 614 767 988

Is there any intention or history of self harm? e.g cutting, eating disorders, suicide attempts, other mental health issues No Yes

Please describe:

Is the child or young person currently involved with any other support services? E.g DoCS, Headspace, Veritas. No Yes

Please describe:

Any other areas of concern

Please describe:

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