



## REFERRAL TO GENERALIST COUNSELLING SERVICE

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**Referral Date:**

Client's Details
Name:
Date of Birth:
Address:
Home Phone:
Mobile Phone:

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

Is there any current or previous domestic violence?	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>



**Is there any intention or history of self harm? e.g cutting, eating disorders, intentional overdose, suicide attempts**

No  Yes

**Is she currently involved with any other support services? E.g DoCS, Mental Health, Women's Housing.**

No  Yes

**Other areas of concern**

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

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ABN 28 614 767 988*