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PO Box 674, Bathurst, NSW 2795
Phone: 02 6331 4133 * Fax: 02 6332 4310
Email: information@cwwhc.org.au

CENTRAL WEST WOMEN'S HEALTH CENTRE
SUPPORT FOR WOMEN & CHILDREN

GENERALIST COUNSELLOR REFERRAL FORM

Referral Date:

Person Making Referral			
Name:			
Position:			
Organisation:			
Contact Number:			
Email Address:			
Preferred Method of Feedback:	Email ❑	Phone ❑	No Feedback ❑

Client's Details	
Name:	
Date of Birth:	
Address:	
Home Address (if different):	Preferred contact?
Home Phone:	❑
Mobile Phone:	❑
Email:	❑
Can we leave a message? Voice (Mob) ❑ SMS ❑ Voice (Home) ❑	
Best time of day to contact? AM ❑ PM ❑ Notes:	
Previous counselling details:	

Is there any current or previous domestic violence? **No** ❑ **Yes** ❑
If yes, please briefly describe

Funded by NSW Health (Western NSW Local Health District), NSW Department of Communities and Justice, and donations from the community.
ABN 28 614 767 988

Do you have immediate concerns for the safety of this client or her children? If yes please note any action taken **No** ❑ **Yes** ❑
If yes, please briefly describe
Are you aware of any history of sexual assault? (eg. adult survivor of CSA, child victim of CSA or adult sexual assault survivor) **No** ❑ **Yes** ❑
If yes, please briefly describe
Is there any intention or history of self harm? (eg. cutting, eating disorders, intentional overdose, suicide attempts) **No** ❑ **Yes** ❑
If yes, please briefly describe
Is she currently involved with any other support services? (eg. FaCS, Mental Health, Women's Housing) **No** ❑ **Yes** ❑
If yes, please briefly describe

Reason for referral and other areas of concern

Australian Privacy Principle # 5: Notification of the collection of personal information

❑ I have notified the client regarding the nature of the information disclosed on this form and the client is fully aware of this referral.

Signature of referrer: ……**Date:** …./…./…..