Derby Women's Centre
Improving the Quality of Life for Women in Derby and Derbyshire

Client Number (after assessment)

Counselling Service – Referral and assessment form

Date of referral	Referred by: Self	*Date of assessment:*

Name: **DOB:**		**How did you hear about DWC Counselling Service?**
Address: *Who do you live with?* **Post Code:**		**OK to write to you at this address?**
Telephone Numbers:		**OK to leave Message?** ***Emergency Contact:***
Ethnic Origin:	**Disabled? Yes/No**	**Any other requirements?**
Any current involvement, with any other service e.g. Mental Health Services/ Social Services/ Probation / Other? **No** ***GP Name and address***		***Current Medication*** ***Core Completed:*** ***Yes/ No*** ***Date:***
Have you ever accessed other services within DWC?		***Have you had counselling before? If so where/when?***
Referral completed by:		
Have you any history of emotional breakdown	***Have you ever had any suicidal thoughts or attempted suicide?***	
Do you have any obsessional	***Do***	

4 Leopold Street,
Derby DE1 2HE
Telephone/Fax: 01332 341633
Email address:kaths@derbywomenscentre.co.uk
Website address: derbywomenscentre.co.uk

thoughts/behaviours?	
Background/History	
What are your expectations of counselling?	***Availabiltiy:*** ***Agreed donation:***

Counselling Co-ordinators signature……..***Date:***……