

For the benefit of the Support Programme and its members, we need to assess your patient's compatibility.

Please send your completed referral form to us, by post Women for Change, PO Box 3636, Stratford-Upon-Avon, CV37 8WF, or by fax 01789 490715.

If you have any questions about the Support Programme, please call 01789 490715 or email info@womenforchange.org.uk

Support Programme Referral Form

Patient details please print

Surname	<input type="text"/>
Forename	<input type="text"/>
Date of birth	<input type="text"/>
Address	<input type="text"/>
Postcode	<input type="text"/>
Tel no	<input type="text"/>

Patient's GP

Name	<input type="text"/>
Surgery	<input type="text"/>
Address	<input type="text"/>
Postcode	<input type="text"/>
Tel no	<input type="text"/>

Patient history

Please provide a brief patient history, with details of the counselling and other therapies already completed.

We need to assess their compatibility with the Support Programme. **Please tick which of the following statements are accurate for this patient:**

- The patient is able to share her abuse history
- The patient has clear memories about her abuse
- The patient is able to give and receive support
- The patient is free from drugs that inhibit her functioning in the Programme
- The patient is free from alcohol dependency (one year of sobriety)
- The patient will have a support system outside the Programme
- The patient has been free from suicide attempts for the past six months

Referrer's details (person completing the form)

Referrer's name	<input type="text"/>
Job Title	<input type="text"/>
Clinic or Surgery	<input type="text"/>

Tel number	<input type="text"/>
Bleep / Mobile No	<input type="text"/>
Signature	Date