**REFERRAL FORM TO INNER CITY WOMEN’S GROUP**

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| **Date of Referral:**  |  | **Referring Agency** |  |
| **Referring Support Worker’s Name:** |  | **Support Worker’s Phone:** |  |
| **Support Worker’s Email:** |  |
| **Client’s Name:** |  | **Client’s Date of Birth:** |  |
| **Client’s Phone No:** |  | **Protection Order in place** | YES / NO / Applying | **MVCOT (cfys):**  | Y / N |
| **Client’s Address:** |  | **Court/ Corrections:** | Y / N |
| **ICWG Programme referred to:** | Breaking the Cycle | Irate | Reclaiming Myself | Individual Counselling |
| **Other agencies involved:** |  |
| **Comments:**  |
| **Consent from client for referral:**  | Yes / No | **PLEASE SEND REFERRAL FORM TO:**  | **tammy@icwg.org.nz** |