**CEDAR Referral Form**

|  |  |
| --- | --- |
| Your name |  |
| How many children do you have? |  |
| What age(s) are your children? |  |
| Your contact telephone number |  |

1. Have you previously experienced domestic abuse?

Yes No

1. Are you still in that abusive relationship?

Yes No

1. Do you have more than 50/50 contact with your children?

Yes No

Best time to contact *(please tick accordingly)*

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | Monday | Tuesday | Wednesday | Thursday | Friday | Saturday | Sunday |
| Morning |  |  |  |  |  |  |  |
| Afternoon |  |  |  |  |  |  |  |
| Evening |  |  |  |  |  |  |  |

Any other information/comments/questions:

A member of staff will get in contact with you within 7 working days to discuss this referral.