



The South West Child & Adolescent and Family Services (CAFS) is a family community organisation that provides counselling and case management for children, adolescents and families. CAFS is not a crisis or NDIS service. CAFS primary goal is to work towards the betterment of maintaining the family unit to prevent family breakdown.

The referral eligibility criteria for CAFS are as follows, but not limited to:

- Must reside within the Liverpool, Fairfield, Campbelltown & Bankstown Local Government Area
- Adult referee must have children under the age of 18
- Referred children & young person's must be under the age of 18
- The presenting problem must affect the family unit dynamics
- The referee must not require crisis management
- Referee must not experience significant debilitating mental health diagnosis. i.e psychosis, chronic suicidality, eating disorders, autism spectrum disorder level II & III
- Referee is willing to consent to participate in the information sharing across of key partners. i.e Government Data Exchange platform
- Referee is not a perpetrator of domestic violence, family violence and / or sexual offences
- CAFS does not provide medico-legal or forensic support i.e legal reports or assessments

What is the referral process like?

- Complete & send CAFS referral form to intake@cafs.com.au
- Referrals are reviewed during our fortnightly intake meetings
- Clinical team will assesses each referral
- CAFS will inform you of the referral outcome
- If a referral is accepted, the case will be allocated a case worker and CAFS will contact the client to arrange an appointment

Should you have any questions, please do not hesitate to call us on **(02) 9826 8077** for further enquires.



CAFS REFERRAL FORM

Details of Referred Primary Person

Full Name: <input type="text"/>	
Date of Birth: <input type="text"/>	Gender: Male <input type="radio"/> / Female <input type="radio"/> / Other <input type="radio"/>
Phone: <input type="text"/>	Email: <input type="text"/>
Address: <input type="text"/>	
Suburb: <input type="text"/>	Postcode: <input type="text"/>
Local Government Area: <input type="radio"/> Liverpool / <input type="radio"/> Fairfield / <input type="radio"/> Bankstown / <input type="radio"/> Campbelltown	
School (If Applicable)	<input type="text"/>
Grade Year	<input type="text"/>

Name Other Family Members/ Significant Persons	Relationship to primary client	Age	Phone Number
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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Presenting Problems		
1. Disorder of Childhood: ODD / ADHD / ASD <input type="checkbox"/>	2. Anxiety (Child) <input type="checkbox"/>	3. Anxiety (Parent) <input type="checkbox"/>
4. Depression (Child) <input type="checkbox"/>	5. Depression (Parent) <input type="checkbox"/>	6. Alcohol and other Drugs (Child) <input type="checkbox"/>
7. Alcohol and other Drugs (Parent) <input type="checkbox"/>	8. ROSH: Physical / Neglect / Emotional / Sexual <input type="checkbox"/>	9. Home Leaving / Homelessness / Housing <input type="checkbox"/>
10. School Refusal / Stress <input type="checkbox"/>	11. Disability (Intellectual) <input type="checkbox"/>	12. Disability (Physical) <input type="checkbox"/>
13. Eating Disorders <input type="checkbox"/>	14. Self-harm / Suicidal <input type="checkbox"/>	15. Family Restoration <input type="checkbox"/>
16. Behavioural / Behaviour Management Issues <input type="checkbox"/>	17. Aggressive Behaviour / Anger Management Issues <input type="checkbox"/>	18. Domestic / Family Violence <input type="checkbox"/>
19. Adjustment Issues <input type="checkbox"/>	20. Parenting Issues <input type="checkbox"/>	21. Bereavement Issues <input type="checkbox"/>
22. OCD <input type="checkbox"/>	23. Trauma <input type="checkbox"/>	24: Other <input type="checkbox"/>

Note: The above presenting conditions are for assessment purposes & to view clients global functioning and may not necessarily meet our referral criteria.



History and Current Situation:

Expectation of Referrer:

Hospitalisation:

Has the referee been admitted to hospital in the past 24 months? Yes / No

If YES, which hospital?

Date of admission?

Length of stay?

Reason for stay?





Referral Source:

1. Self <input type="checkbox"/>	2. Family <input type="checkbox"/>	3. DCJ <input type="checkbox"/>	4. Education / School Sector <input type="checkbox"/>	5. Health Sector <input type="checkbox"/>
6. Legal Sector <input type="checkbox"/>	7. Refuge Service <input type="checkbox"/>	8. Centrelink <input type="checkbox"/>	9. Community Based Organisation <input type="checkbox"/>	10. Other <input type="checkbox"/>

Name of Referrer:	<input type="text"/>		
Contact Details:	Ph: <input type="text"/>	Email: <input type="text"/>	
Relationship to Client:	<input type="text"/>		

Other Agencies Involved:

Organisation	Contact Name	Contact Number
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

Are there any other further comments or information you would like to include in relation to the referral?



Statistical Information:

What country was the main referred person born in?

Main language spoken at home? *If you speak more than one language at home, please write the language that is spoken most often.*

Interpreter Required? Yes No

Do you identify as Aboriginal or Torres Strait Islander?

<input type="checkbox"/> 1	No
<input type="checkbox"/> 2	Aboriginal
<input type="checkbox"/> 3	Torres Strait Islander
<input type="checkbox"/> 4	Aboriginal and Torres Strait Islander

Do you have any of the following impairments, conditions or disabilities?

Please select all that apply. Medical documentation is not required. For information about each category speak to your practitioner or service provider.

<input type="checkbox"/> 1	Intellectual learning
<input type="checkbox"/> 2	Psychiatric
<input type="checkbox"/> 3	Sensory/speech
<input type="checkbox"/> 4	Physical/diverse
<input type="checkbox"/> 5	None



Are you homeless or at risk of being homeless?

<input type="checkbox"/> 1	Yes
<input type="checkbox"/> 2	No
<input type="checkbox"/> 3	At risk

How would you describe the makeup of your household?

<input type="checkbox"/> 1	Single (person living alone)
<input type="checkbox"/> 2	Sole parent with dependent(s)
<input type="checkbox"/> 3	Couple
<input type="checkbox"/> 4	Couple with dependent(s)
<input type="checkbox"/> 5	Group of related adults
<input type="checkbox"/> 6	Group of unrelated adults
<input type="checkbox"/> 7	Homeless/no household



Please select your relevant Employment Status?

<input type="checkbox"/> 1	Full time Employed / Paid Work Full Time
<input type="checkbox"/> 2	Part Time Employed / Paid Work Part Time
<input type="checkbox"/> 3	Casual / Unpaid work (includes Volunteering)
<input type="checkbox"/> 4	Not working / Not looking for work
<input type="checkbox"/> 5	Unemployed / (Not working, but looking for work)
<input type="checkbox"/> 6	Studying full time
<input type="checkbox"/> 7	Studying part time
<input type="checkbox"/> 8	Caring
<input type="checkbox"/> 9	Parenting

Main Source of income?

<input type="checkbox"/> 1	Nil Income
<input type="checkbox"/> 2	Employee Salary / Wages
<input type="checkbox"/> 3	Self Employed
<input type="checkbox"/> 4	Government Payment / Pensions / Allowances

What level of education have you achieved?

<input type="checkbox"/> 1	Primary
<input type="checkbox"/> 2	High School
<input type="checkbox"/> 3	TAFE / Diploma Equivalent
<input type="checkbox"/> 4	Bachelor Degree Level
<input type="checkbox"/> 5	Post Graduate Degree Level

OFFICE USE ONLY

Allocated Date: <input type="text"/>	Date Caseworker: <input type="text"/>
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Further Notes / Referral Outcome	
Date	Notes
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