SOUTH WEST CHILD ADOLESCENT & FAMILY SERVICES
Green Valley District Centre
179-183 Wilson Rd, Green Valley NSW 2168
Next to the Valley Plaza
PO BOX 1066, Green Valley 2168
Phone: 9826 8077 Intake@cafs.com.au
ABN: 53584214270

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 REFERAL FORM

Details of Referred Primary Person

Full Name:	
Date of Birth:	**Gender:** Male ○ / Female ○ / Other ○
Phone:	**Email:**
Address:	
Suburb:	**Postcode:**
Local Government Area: ○ Liverpool / ○ Fairfield / ○Bankstown / ○Campbelltown	

School (If Applicable)	
Grade Year	

Name Other Family Members/ Significant Persons	Relationship to primary client	DOB	Phone Number

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

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 ☐	2. Family ☐	3. DCJ ☐	4. Education / School Sector ☐	5. Health Sector ☐
6. Legal Sector ☐	7. Refuge Service ☐	8. Centrelink ☐	9. Community Based Organisation ☐	10. Other ☐

Name of Referrer:		
Contact Details:	Ph:	Email:
Relationship to Client:		

Other Agencies Involved:

Organisation	Contact Name	Contact Number

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?

☐ 1	No
☐ 2	Aboriginal
☐ 3	Torres Strait Islander
☐ 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.

☐ 1	Intellectual learning
☐ 2	Psychiatric
☐ 3	Sensory/speech
☐ 4	Physical/diverse
☐ 5	None

Are you homeless or at risk of being homeless?

☐ 1	Yes
☐ 2	No
☐ 3	At risk

How would you describe the makeup of your household?

☐ 1	Single (person living alone)
☐ 2	Sole parent with dependent(s)
☐ 3	Couple
☐ 4	Couple with dependent(s)
☐ 5	Group of related adults
☐ 6	Group of unrelated adults
☐ 7	Homeless/no household

Please select your relevant Employment Status?

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

Main Source of income?

☐ 1	Nil Income
☐ 2	Employee Salary / Wages
☐ 3	Self Employed
☐ 4	Government Payment / Pensions / Allowances

What level of education have you achieved?

☐ 1	Primary
☐ 2	High School
☐ 3	TAFE / Diploma Equivalent
☐ 4	Bachelor Degree Level
☐ 5	Post Graduate Degree Level

OFFICE USE ONLY

Allocated Date:	Date Caseworker:

Further Notes / Referral Outcome	
Date	Notes