



Child and Adolescent Forensic Service (CAFS)

Referral form

For any queries relating to this referral, please contact the CAFS triage officer between 8.30am and 4.30pm on (08) 6382 2500. Please email completed referrals, along with supporting documentation, to SFMHS.CAFSTriage@health.wa.gov.au

Child and Adolescent Forensic Service (CAFS) is a statewide service offering specialist forensic risk advice and support for children and adolescents with significant mental health difficulties who are at risk of serious offending. CAFS includes psychosocial and cultural supports delivered by Yirra Dandjoo.

Referrals will be accepted from providers on the young person's existing treatment team. It is expected that the referring agency* retain primary case management responsibilities or hand over to another suitable clinical service during CAFS' involvement, to ensure consistent and coordinated support.

*Not applicable for Detention Transition or some CLMI referrals.

Inclusion criteria

All the following criteria must be met. The young person being referred must:

- Be aged 10-18 years at the time of the referral
- Have serious mental health needs - a diagnosed serious mental illness or severe difficulties that exceed developmental norms and significantly affect daily functioning
- Have a recent history of serious offending, or believed to be at risk of serious offending, including but not limited to:
 - Violent offences
 - Sexual offences
 - Stalking or relational violence

- Arson
- Fixated threats or violent extremism.
- Have a likely link between the mental health issues and the offending or risk of offending.

Exclusion criteria

- Primary diagnosis of a neurodevelopmental disorder (eg: intellectual disability, ASD, ADHD) or substance use disorder with no co-occurring significant mental health issue.
- Referral is only for diagnosis of a neurodevelopmental disorder or cognitive impairment.
- Young person is exclusively a risk to themselves.
- Needs are better met by another service.

The CAFS team will collate all relevant information and determine the mode of assessment (case conference or face-to-face assessment with the young person) and type of psychological and risk assessment tools that may be required (eg: SAVRY, J-SOAP II, TRAP-18).

CAFS is a voluntary service and signed parental/guardian consent is required to progress a referral.



Referrer details

Date of referral:			
Name & position:			
Organisation:			
Address:			
Phone:		Fax:	
Email:			
Have you directly assessed the patient?	Yes ☐	No ☐	Date of last assessment:
Has the parent/guardian consented to this referral being made?			Yes ☐ No ☐
I acknowledge that: • All inclusion criteria have been met, and • A suitable clinical service will maintain their involvement in the young person's care and can implement recommendations made by CAFS.			Yes ☐ No ☐

Young person's details

Given name:		Surname:		
Sex at birth:		Identified gender:		
Preferred name:		Preferred pronouns:		
DOB:		UMRN:		
Primary address:			Postcode:	
Phone:		Email:		
Aboriginal and Torres Strait Islander:	Aboriginal ☐ TSI ☐ Neither Aboriginal nor TSI ☐			
Other ethnicity:				
Primary language:		Interpreter required:	Yes ☐	No ☐
Current school:				
School year:		School phone:		

Legal status (if applicable)

Legal status (eg: MHA, CLMI, Legal Order, Child Protection Order):			
Expiry date of above (if applicable):			
Primary contact within Youth Justice Services (eg: Youth Justice Officer, Juvenile Justice Team, Metro Youth Bail Service):		Phone:	
Expected release or discharge date:		Next court date:	

GP practice and provider details

Practice name:			
Practice address:		Postcode:	
Phone:		Email:	
GP name:			

Parent or carer details

Name		Phone:	
Email:		Relationship to child:	
Address:			
Name		Phone:	
Email:		Relationship to child:	
Address:			
Name		Phone:	
Email:		Relationship to child:	
Address:			

Child Protection and Family Support (CPFS) involvement (if applicable)

Current CPFS involvement?	Yes ☐	No ☐	Previous CPFS involvement?	Yes ☐	No ☐
Is the young person a child in care?				Yes ☐	No ☐
Case worker contact details:					

Reason for referral

Describe the presenting problems, including onset, duration and frequency. Include any historical mental health diagnoses and describe how the problems are affecting the young person's everyday functioning (home, school, social). What forensic concerns do you have around serious offending or significant risk to others? What do you need from CAFS?

Previous mental health and other service history

Mental health and other therapeutic services, NDIS, Alcohol and Other Drug (AOD) services, Youth Justice Services, Police. Any previous diagnoses or treatments provided.

Past medical history

Physical health (including neurodevelopmental) conditions, allergies and any drug adverse reactions.

Current social circumstances

Explain the young person's current living situation, family dynamics, school achievements and attendance rate, peer relationships, social media use, recreational activities/interests, past and current substance use.

Adverse childhood experiences

☐ Verbal abuse	☐ Physical abuse	☐ Sexual abuse
☐ Neglect (emotional)	☐ Neglect (physical)	☐ Witness to family violence
☐ Parental separation/divorce	☐ Parent/carer substance use	☐ Parent/carer mental health
☐ Parent/carer imprisonment	☐ Other:	

Other services or agencies involved

Agency:		Contact name:	
Phone:		Email:	
Agency:		Contact name:	
Phone:		Email:	
Agency:		Contact name:	
Phone:		Email:	

Additional information

Please include the following documentation (if applicable/available)

- ☐ SSCD – Initial assessments, CRAMP, TSDP
- ☐ Medication history
- ☐ Discharge summaries
- ☐ Education reports/documents – OSI, IEP, IEB
- ☐ Professional reports – psychiatric, paediatric, allied health
- ☐ Offending history/copies of legal orders – CLMI Act, Young Offenders Act, Family Court

Please be advised CAFS is not a crisis service and cannot provide crisis management, including out of hours support. If urgent mental health support or advice is needed, please contact CAMHS Crisis Connect on 1800 048 636.

For any immediate and serious concerns for potential violence or other serious offending, call the police on 000.

**DO NOT FORGET TO COMPLETE AND ATTACH THE
AUTHORITY TO RELEASE FORM ON THE FOLLOWING PAGE.**



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Child and Adolescent Forensic Service

243 James St, Northbridge WA 6003
 (08) 6382 2500
 SFMHS.CAFSTriage@health.wa.gov.au

This document can be made available in
alternative formats on request.

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Website: See State Forensic Mental Health Services
(click the Child and Adolescent Services dropdown) or scan the QR code.



AUTHORITY TO EXCHANGE INFORMATION

(To be completed by parent or guardian)

I, _____
hereby authorise the Child and Adolescent Forensic Service to share information about

(young person's name) _____

(young person's DOB) _____ with Yirra Dandjoo (Centrecare/
Waalitj Foundation) and the following services:

Agency/service provider/ individual	Specific details of provider or conditions of consent
☐ Other family/caregivers	
☐ General practitioner	
☐ NDIS/therapy providers	
☐ Mental Health Services	
☐ Hospitals	
☐ Police	
☐ Department of Justice	
☐ Department of Communities	
☐ Department of Education	
☐ State Forensic Services - Neurodevelopmental and Mental health service (NDMHS)	
☐ Other	

The purpose of this form is to ensure confidentiality and promote continuity of care.
This consent is valid until such time as I withdraw consent.

Signed: _____ Date: _____
(Parent/Guardian)

Print name: _____

WITHDRAWAL OF CONSENT:

Date: _____

Signed: _____
(Mature Minor Patient/Parent/Guardian)

Print name: _____

Witness: _____