

CSATS Advocacy Service – Referral Information

This client advocacy service will be the entry point for any clients and/or families wanting to access Anglicare WA's Child Sexual Abuse Therapy Service (CSATS). Referrals received will be assessed for suitability for active case management and therapy services.

Instructions to complete this form:

- **Complete this form electronically.**
- Use the **TAB** key to move through the form or mouse click the relevant section.
- Send this form to: info@anglicarewa.org.au
(>File>Send To>Mail Recipient [as attachment])

Referral Agency Details					
Date	/ /	Name of Agency			
Address of Agency					
Name & Role of Referral Person					
Phone No.		Fax No.		E-mail	

Parent/Guardian Details						
Parent/Guardian 1	Full Name					
	DOB	/ /	Preferred Pronouns			
	<input type="checkbox"/> Aboriginal		<input type="checkbox"/> Torres Strait Islander			
	<input type="checkbox"/> Aboriginal/Torres Strait Islander		<input type="checkbox"/> CALD			
	<input type="checkbox"/> Unknown		<input type="checkbox"/> Ethnicity:			
	Is an interpreter required?				<input type="checkbox"/> Yes <input type="checkbox"/> No	
	If so, in what language?					
	Has the Department of Child Protection been involved?				<input type="checkbox"/> Yes <input type="checkbox"/> No	
Is involvement ongoing?				<input type="checkbox"/> Yes <input type="checkbox"/> No		
Address						
Suburb				Postcode		
Home Phone		Work	Mobile			
E-mail						
Parent/Guardian 2	Full Name					
	DOB	/ /	Preferred Pronouns			
	<input type="checkbox"/> Aboriginal		<input type="checkbox"/> Torres Strait Islander			
	<input type="checkbox"/> Aboriginal/Torres Strait Islander		<input type="checkbox"/> CALD			
	<input type="checkbox"/> Unknown		<input type="checkbox"/> Ethnicity:			
	Is an interpreter required?				<input type="checkbox"/> Yes <input type="checkbox"/> No	
	If so, in which language?					
	Has the Department of Child Protection been involved?				<input type="checkbox"/> Yes <input type="checkbox"/> No	
Is involvement ongoing?				<input type="checkbox"/> Yes <input type="checkbox"/> No		
Address						

Suburb				Postcode	
Home Phone		Work		Mobile	
E-mail					
Confidential Needs	<input type="checkbox"/> Ok to contact 2 nd parent/ guardian		<input type="checkbox"/> Ok to leave a voice/text message		

Child Details						
Child 1	Full Name					
	Age	Date of Birth		Preferred Pronouns		
	<input type="checkbox"/> 0-5	/ /		<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Gender Diverse		
	<input type="checkbox"/> 6-11	/ /		<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Gender Diverse		
	<input type="checkbox"/> 12-17	/ /		<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Gender Diverse		
	<input type="checkbox"/> 18	/ /		<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Gender Diverse		
	<input type="checkbox"/> Aboriginal		<input type="checkbox"/> Torres Strait Islander			
	<input type="checkbox"/> Aboriginal/Torres Strait Islander		<input type="checkbox"/> CALD			
	<input type="checkbox"/> Unknown		<input type="checkbox"/> Ethnicity:			
Is an interpreter required?					<input type="checkbox"/> Yes <input type="checkbox"/> No	
If so, in which language?						
Child 2	Full Name					
	Age	Date of Birth		Preferred Pronouns		
	<input type="checkbox"/> 0-5	/ /		<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Gender Diverse		
	<input type="checkbox"/> 6-11	/ /		<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Gender Diverse		
	<input type="checkbox"/> 12-17	/ /		<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Gender Diverse		
	<input type="checkbox"/> 18	/ /		<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Gender Diverse		
	<input type="checkbox"/> Aboriginal		<input type="checkbox"/> Torres Strait Islander			
	<input type="checkbox"/> Aboriginal/Torres Strait Islander		<input type="checkbox"/> CALD			
	<input type="checkbox"/> Unknown		<input type="checkbox"/> Ethnicity:			
Is an interpreter required?					<input type="checkbox"/> Yes <input type="checkbox"/> No	
If so, in which language?						
Child 3	Full Name					
	Age	Date of Birth		Preferred Pronouns		
	<input type="checkbox"/> 0-5	/ /		<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Gender Diverse		
	<input type="checkbox"/> 6-11	/ /		<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Gender Diverse		
	<input type="checkbox"/> 12-17	/ /		<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Gender Diverse		
	<input type="checkbox"/> 18	/ /		<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Gender Diverse		
	<input type="checkbox"/> Aboriginal		<input type="checkbox"/> Torres Strait Islander			
	<input type="checkbox"/> Aboriginal/Torres Strait Islander		<input type="checkbox"/> CALD			
	<input type="checkbox"/> Unknown		<input type="checkbox"/> Ethnicity:			
Is an interpreter required?					<input type="checkbox"/> Yes <input type="checkbox"/> No	
If so, in which language?						

Please detail family structure below:

--

Sexual Abuse / Offence		
1.	Describe the incident/s of sexual abuse and/or sexually harmful behaviour, include where possible details of those involved, the nature of the abuse and a time frame	
2.	Has the child or young person experienced or displayed technology facilitated harm or abuse?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3.	Has the Department of Child Protection been involved?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4.	Is involvement ongoing?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5.	Is there a current safety plan? If so, please forward with referral	<input type="checkbox"/> Yes <input type="checkbox"/> No
6.	Has this matter been reported to Police?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Department of Child Protection use only:	Has the abuse been substantiated?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Legal Status: are there court proceedings regarding this case? Are there any Court or Police orders in place? Are there court proceedings for other matters(e.g. Family Court, criminal proceedings)?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Police Involvement: are there any current Police investigations in process?		<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes to the above two questions, please provide details:		
Outline the current role of the Department of Child Protection in this case:		
Outline how safe you would regard the child to be, include any steps that have been taken to ensure the child's safety/other children's safety:		
Outline any other agencies currently or previously involved with this family and the nature of the involvement:		

Does the child, young person or parent/guardian require any other supports? (i.e. emergency relief, financial counselling, housing support, mental health or NDIS)

Any other relevant information (i.e. family history of violence: drug and alcohol use, psychological / psychiatric issues, motivation, perception of counselling, etc.)?

Client's Consent	
I confirm that:	
• I am aware that a referral is being made on my behalf to Anglicare WA to access Services they provide.	<input type="checkbox"/>
• I give my permission for Anglicare WA to contact me about my referral.	<input type="checkbox"/>
• I give permission for Anglicare WA to contact the person referring me for further information if required.	<input type="checkbox"/>
• Anglicare WA can enter the details provided on this form onto their database for the purpose of contacting me or my nominated person and to record that a referral was received.	<input type="checkbox"/>
• The information on this form can be shared with Anglicare WA for the purpose of determining eligibility for Anglicare WA Services.	<input type="checkbox"/>
• I understand that appointments will not be booked until I or my nominated person has received direct contact from Anglicare WA	<input type="checkbox"/>
• I understand that this referral does not guarantee access to Anglicare WA Services as I may not be eligible. In this event, Anglicare WA will advise me, my nominated person and/or the referring agency and will, wherever possible, advise on other potential supports available.	<input type="checkbox"/>
<p>Anglicare WA takes all reasonable steps to ensure that all personal and sensitive information is protected in accordance with the Australian Privacy Principles as contained in the <i>Privacy Act 1988</i> (as amended). More information can be found on our website Privacy Anglicare WA or by contacting 1300 11 44 46 or email info@anglicarewa.org.au.</p>	
Client's Signature of Consent	
Name	
Signature	
Date	Click or tap to enter a date.
Relationship to Client	Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Carer <input type="checkbox"/> Nominated Person <input type="checkbox"/>
Name	
Signature	
Date	Click or tap to enter a date.
Staff Signature – I confirm that consent has been explained to the client and/or nominated person	
Name	
Signature	
Date	Click or tap to enter a date.