

## Referral Form for SACS: Targeted Family Support

### Sexual Abuse Counselling Service – Cairns

*To ensure a prompt response to your referral, please complete as much detail/information as possible on this form.*

**Catchment:** We accept referrals for clients residing in Cairns, which include the following suburbs:  
*Palm Cove, Clifton Beach, Kewarra Beach, Trinity Beach, Trinity Park, Smithfield, Yorkey’s Knob, Holloways Beach, Machans Beach, Cairns North, Edge Hill, Whitfield, Stratford, Freshwater, Redlynch, Kamerunga, Caravonica, Bentley Park, Bayview Heights, Earlvile, Kanimbla, Mooroolooloolo, Manoora, Manunda, Westcourt, Bungalow, Woree, White Rock, Mount Sheridan, Lamb Range, Earlvile, Gordonvale.*

**Referral Criteria:**

1. **LEGAL GUARDIAN/S** consent to the referral (both parents if applicable)
2. Referral is for a child or young person (0-18 years) who has been sexually groomed, abused or assaulted
3. Referral is for a child or young person (0-18 years) who requires personal safety education or safety planning.
4. Caregivers are willing and able to participate in and support the therapeutic process.
5. There are no current family law court proceedings taking place.

**Referrer details**

Date of referral	
Name of person referring	
Phone contact	
Email address	
Relationship to child/ young person and/or the child’s parent, carer or family	<input type="checkbox"/> Parent/ Carer <input type="checkbox"/> Extended family <input type="checkbox"/> Friends <input type="checkbox"/> Other <input type="checkbox"/> Professional – NGO <input type="checkbox"/> Professional – Gov <input type="checkbox"/> Professional – Health <input type="checkbox"/> Professional – Education <input type="checkbox"/> Professional – Police

**Please note, cases are allocated based on priority level**

**Priority 1:** Children under 18 who have been sexually abused, groomed or assaulted and are assessed as being at high risk of immediate harm from self or others

**Priority 2:** Children under 18 who have been sexually abused, groomed or assaulted

**Priority 3:** Children under 18 who are at risk of sexual harm (Protective Behaviours)



## Child / young person details – one child per referral

(please indicate which priority applies for each client below)

<b>Name:</b>		<b>Priority 1-3</b>	<input type="checkbox"/>
Date of birth:		Gender:	Ethnicity:
School & Grade:		If ATSI name of identified support:	

### Consent Clarification

<p>For the purpose of consent and the release of information, <b>who holds guardianship of the child/young person?</b>          For Birth Parent or other, please include their name.</p> <p><input type="checkbox"/> <b>Birth parent</b>   <input type="checkbox"/> <b>Family/ Kinship</b>   <input type="checkbox"/> <b>Other, please specify:</b></p>
Type of order/ If applicable:

### Current living arrangements

(who is child/young person currently living with?)

Guardian:	<input type="checkbox"/> Parent(s)	<input type="checkbox"/> Kinship carer	<input type="checkbox"/> Foster carer	<input type="checkbox"/> Other
<b>Details of Guardian(s)</b>				
Please advise adults living with child/children that they will be involved in our intervention.				
<b>Name:</b>		Relationship to the child:		
Date of Birth:				
Day time phone:		Mobile:		

<b>Name:</b>		Relationship to the child:		
Date of Birth:				
Day time phone:		Mobile:		
Address <input type="checkbox"/> residential, <b>or</b> <input type="checkbox"/> postal:				

## Complete for referrals regarding sexual abuse and/or sexual grooming

### Person (s) who harmed the child

Name (if known)	Relationship to Child	Frequency of contact with child

### Details of Abuse

Please describe the acts of abuse that have been disclosed or uncovered (this includes online concerns).	
When did abuse occur or commence?	
Frequency and duration of the abuse (if known)	
Please describe any observations of behaviour change and symptoms arising since the disclosures (e.g. trauma symptoms, sexualised behaviour, etc.)	

### Disclosure details

Child Safety Investigation and Assessment complete?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Outcome?	<input type="checkbox"/> Substantiated <input type="checkbox"/> Substantiated at Risk <input type="checkbox"/> Unsubstantiated
Safety Plan Completed?	Date _____ Attached <input type="checkbox"/> Yes <input type="checkbox"/> No When is review required? _____
Criminal investigation complete?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have charges been laid?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Name of CPIU/Task Force Argos Investigation Officer:	
Office of CPIU Officer:	Telephone number:

## Information for our counsellors

How stable is the current home / family environment? Include in your answer some comments on whether the child's family /carer is able to support child during and after counselling.

Act for Kids Sexual Abuse Counselling occurs in the Program's Counselling Rooms in Bungalow, Cairns. We do offer tele-health. Does the client have access to laptop, tablet or mobile phone?

Are there any other support services, or organisations actively engaged with this family or child/young person? If yes, please give details. E.g. FIS, IFS, CYMHS, Evolve

Is there a diagnosis or disability for any of the referred people?  Yes  No Please include details

Are there any special needs requirements for the clients (e.g. interpreter, medical, cultural, support person, FPP etc.)? If yes, please give contact details.

Are there specific dietary requirements, allergies or sensitivities the SACS team should be aware of?

### THANK YOU FOR YOUR REFERRAL

To send your referral or for more information about process or waitlist status, please use the following information to call or email:

**Sexual Abuse Counselling Service (SACS) – Cairns (Act for Kids)**

Please email your referral to [sacscairns@actforkids.com.au](mailto:sacscairns@actforkids.com.au) or call **07 4033 8550** or **0407 049 576**