Government of **Western Australia**
Child and Adolescent Health Service

CAHDS referral form

Complex Attention and Hyperactivity Disorders Service (CAHDS)

If you have questions or wish to discuss the request before completing this form, please contact the CAHDS Choice Coordinator on 6456 0214.

Name:

Date of birth: Gender: ☐ M ☐ F

Address:

Postcode:

Parent or carer details

Mother's name: Phone:

Father's name: Phone:

Preferred contact:

Is the child under the care of CPFS? ☐ Yes ☐ No

Case Manager name: Phone:

Diagnosis

When diagnosed and clinician's name:

Referrer details

Name:

Profession:

Address:

Phone: Mobile: Fax:

Email:

Availability for contact (preferred days/times):

Declaration

By signing below, you agree to:

- continue to manage the care of the person I referred during CAHDS involvement
- be available for consultation with clinicians from CAHDS
- provide follow up post discharge from CAHDS

Referrer signature: Date:

Current issues

Home:

School/education:

Social:

Medical:

CAHDS, Clinic K, PCH, 15 Hospital Avenue, Nedlands WA 6009 Ph 08 6456 0214 **cahs.health.wa.gov.au**

Service involvement

Please attach copies of assessment reports.

Previous:

Current:

Medications

Medication and adjunct therapies

Previous:

Current:

What do you want from the CAHDS assessment?

Please email the completed form and attached documents to
CAMHS.CAHDS@health.wa.gov.au
or 'Submit form' below

Submit form

CAHDS, Clinic K, PCH, 15 Hospital Avenue, Nedlands WA 6009 Ph 08 6456 0214 **cahs.health.wa.gov.au**