



QPASTT

Queensland Program of
Assistance to Survivors of
Torture and Trauma Inc

REFERRAL FORM

Email: referral@qpastt.org.au

Fax: (07) 3391 6388

People eligible to access QPASTT services include those who have a refugee background and a history of torture and trauma prior to arrival in Australia, and who are experiencing psychological or psychosocial difficulties believed to be associated with their experience of torture and trauma.

QPASTT also offers specialised early intervention programs including:

- (1) Young people [12-24] at risk of suicide or self harm
- (2) Families at risk of relationship breakdown

QPASTT is not a crisis service and is unable to respond immediately.

Further information about QPASTT services is available on www.qpastt.org.au

Very Important → Consent is essential for all QPASTT services.

Is there client consent for QPASTT to contact this person? YES / NO

Can client be contacted directly? YES / NO

Has the parent/s consented to this referral if the person is under 18 years: YES/NO

All referrals are discussed at QPASTT's weekly referral meeting

You will be contacted by QPASTT staff after this meeting.

REFERRAL SOURCE

Date: ____/____/____

Referring Organisation: _____

Name of Worker: _____

Contact Phone: _____

Fax: _____

Mobile: _____

E- mail: _____

Address: _____

PERSON REFERRED (CLIENT) *Please complete one form per person referred*

Family Name: _____

Given Names: _____

Date of Birth: ____/____/____

Country of Origin: _____

Preferred Language/s: _____

Interpreter Required: YES / NO

Male Female

Interpreter preference/s: _____

Migration status: Refugee Refugee-Woman at Risk Special Humanitarian Visa 866
 Person seeking Asylum Permanent resident Australian citizen

Postal Address: PO Box 6254, Fairfield, Qld 4103

Phone: + 61 7 3391 6677 Fax: +61 7 3391 6388

E-mail: admin@qpastt.org.au Website: www.qpastt.org.au

QPASTT is the Queensland representative of the Forum of Australian Services to Survivors of Torture and Trauma.

Date of Arrival:

Address:

Postcode:

Telephone:

Tick box if client does not have a phone

Mobile:

Best time to phone: AM/PM

Please indicate if you have concerns about any other family members:

Number of family members living under same roof as client (including client):

If known, please list all household members of the client including their relationship to the client being referred

Given Name	Surname	Date of Birth	Gender	Relationship to Client
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Referral Information & Indicators

What is the reason for referral?

Please tick and describe if any of the following are present:

Person discloses experience of torture or other traumatic events with or without prompting.	<input type="checkbox"/>
Person discloses injuries or pain which is/are the result of torture, sexual assault or other form of violence.	<input type="checkbox"/>
Person discloses suicide ideation or self harm [Note: Please refer to appropriate service if an immediate risk]	<input type="checkbox"/>
Person is seeking referral as a result of family relationship difficulties.	<input type="checkbox"/>

Psychological screening: Observations (no questions required) or spontaneous disclosures of any the following:

ADULTS (only)		CHILDREN and ADOLESCENTS (only)	
Crying a lot		Sleep problems-too much or too little	
Intense/persistent emotional distress		Nightmares	
Aggressive behaviour or persistent anger		Severe social withdrawal	
Fears of going out/going to work or other fears		Crying a lot	
Severe social withdrawal or appears uncommunicative		Lots of worries	
Repeated expressions of hopelessness		Hyper-alert	
Many persistent worries		Aggressive behaviour or persistent anger	
On alert for things going wrong		Out of control behaviour	
Overreacting to noises etc in environment		Bed-wetting	
Find images or memories distressing		Not wanting to go to school	
Peculiar appearance, behaviour or speech		Unusual behaviours	
Poor memory / concentration		Risk-taking behaviours	
Alcohol or substance abuse		Persistent headaches or other aches	
Poor self care, household care		Failure to thrive in children	
Persistent physical ailments with no medical cause e.g. headaches, neck pain, stomach pain		Very clingy behaviour of children	
Not responding to needs of children, emotional distance		Alcohol or substance abuse (especially for adolescents)	
Persistent and severe sleep difficulties/ nightmares		Frequent tantrums	
Signs of family conflict		Overacting to minor incidents	
Person appears disoriented, incoherent or confused		Expressed threat to harm self or others *	
Person expresses bizarre or illogical belief			
Expressed threat to harm self or others *			
Person discloses or family member discloses that she/he suffers from a mental problem and/or that she/he is being treated for a mental problem (or their words for this)			
** Where there is an immediate risk of harm to self or other please refer to an appropriate service. For non-immediate threats please provide a description.			

Supports

What supports do they have in Australia?

Other current agency involvement including Contact person/s and phone number/s:

Agency/ies:

Name of Worker:

Contact Number/s