



QPASTT

Queensland program of assistance
to survivors of torture and trauma

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

All referrals are discussed at QPASTT's weekly referral meeting

REFERRAL SOURCE

Date: _____ Referring Organisation _____

Name of Worker: _____ Contact Phone: _____

Fax: _____ Mobile: _____

E- mail: _____

Address: _____

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 N/A

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

Family Name: _____

Given Names: _____

Date of Birth: _____ Country of Birth: _____ Ethnicity: _____

Preferred Language/s: _____ Interpreter Required: Yes No

Interpreter preference/s: _____

QPASTT Main Office

ABN: 50043097082

Address: 28 Dibley Street, Woolloongabba Qld 4102

Postal Address: PO Box 6254, Fairfield, Qld 4103

T: +61 (0)7 3391 6677 **F:** +61 (0)7 3391 6388 **E:** admin@qpastt.org.au

Male

Female

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Date of Arrival in Australia: _____

Client has been in Detention No Yes If Yes Date of release from Detention: _____
Place of Detention: _____

Date client received Permanent Residency/Temporary Visa: _____

Address: _____

Postcode: _____

If person attends school which school do they attend?

Mobile: _____

Best time to phone: AM/PM _____

Migration/Visa status -

Please tick one

Unknown

Permanent Resident Visa

Woman at Risk Visa

Australian Citizen

Special Humanitarian
Visa

Temporary Visa

Visa 866

Person Seeking Asylum:

BITA

Community Detention

Bridging Visa (with SRSS
case manager)

Unfunded asylum seeker

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 (Will be used to determine eligibility and triage accordingly)

What is the reason for referral? Individual Counselling Family Counselling Group Work

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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"/>
Note:	
Person discloses injuries or pain which is/are the result of torture, sexual assault or other form of violence.	<input type="checkbox"/>
Note:	
Person discloses suicidal ideation or self harm [Note: Please refer to an emergency service if an immediate risk]	<input type="checkbox"/>
Please Specify:	
Person is seeking referral as a result of family relationship difficulties.	<input type="checkbox"/>
Note: Not known	

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

ADULTS (only)	CHILDREN and ADOLESCENTS (only)
Crying a lot <input type="checkbox"/>	Sleep problems-too much or too little <input type="checkbox"/>
Intense/persistent emotional distress <input type="checkbox"/>	Nightmares <input type="checkbox"/>
Aggressive behaviour or persistent anger <input type="checkbox"/>	Severe social withdrawal <input type="checkbox"/>
Fears of going out/going to work or other fears <input type="checkbox"/>	Crying a lot <input type="checkbox"/>
Severe social withdrawal or appears uncommunicative <input type="checkbox"/>	Lots of worries <input type="checkbox"/>
Repeated expressions of hopelessness <input type="checkbox"/>	Hyper-alert <input type="checkbox"/>
Many persistent worries <input type="checkbox"/>	Aggressive behaviour or persistent anger <input type="checkbox"/>
On alert for things going wrong <input type="checkbox"/>	Out of control behaviour <input type="checkbox"/>
Overreacting to noises etc in environment <input type="checkbox"/>	Bed-wetting <input type="checkbox"/>
Find images or memories distressing <input type="checkbox"/>	Not wanting to go to school <input type="checkbox"/>
Peculiar appearance, behaviour or speech <input type="checkbox"/>	Risk-taking behaviours <input type="checkbox"/>
Poor memory / concentration <input type="checkbox"/>	Persistent headaches or other aches <input type="checkbox"/>
Alcohol or substance abuse <input type="checkbox"/>	Poor peer relationships <input type="checkbox"/>
Poor self care, household care <input type="checkbox"/>	Very clingy behaviour of children <input type="checkbox"/>
Persistent physical ailments with no medical cause e.g. headaches, neck pain, stomach pain <input type="checkbox"/>	Alcohol or substance abuse (especially for adolescents) <input type="checkbox"/>
Not responding to needs of children, emotional distance <input type="checkbox"/>	Frequent tantrums <input type="checkbox"/>
Persistent and severe sleep difficulties/ nightmares <input type="checkbox"/>	Overacting to minor incidents <input type="checkbox"/>
Signs of family conflict <input type="checkbox"/>	Expressed threat to harm self or others * <input type="checkbox"/>
Person appears disoriented, incoherent or confused <input type="checkbox"/>	Bizarre behaviours <u>Specify:</u> <input type="checkbox"/>
Person expresses bizarre or illogical belief <u>Specify:</u> <input type="checkbox"/>	
Expressed threat to harm self or others * <input type="checkbox"/>	<input type="checkbox"/>
Person discloses or family member discloses that she/he suffers from a mental health problem and/or that she/he is being treated for a mental health problem (or their words for this) <input type="checkbox"/>	
Intellectual / Cognitive impairment: suspected <input type="checkbox"/> assessed <input type="checkbox"/> confirmed <input type="checkbox"/>	
Details:	

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*** Where there is an immediate risk of harm to self or others please refer to an emergency service. For non-immediate threats please provide a description above**

Supports

What supports do they have in Australia?

Other current agency or schools/TAFE involvement including Contact person/s and contact details

Agency/Education Centre:

Name of Worker/Teacher:

Contact Number/s:

Email Address:

Please email completed referral form to referral@qpastt.org.au

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