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. In the case of children and youth, QPASTT recognises the effects of intergenerational trauma and provides service to those whose key family member or carer have pre arrival experiences of torture and/or trauma.

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 ☐ Preference:

Male ☐ Female ☐ Transgender Male ☐ Transgender Female ☐ Other ☐

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

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: Protection 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**	Person Seeking Asylum:
☐ Unknown	☐ Permanent Resident Visa	☐ BITA
☐Woman at Risk Visa	☐ Australian Citizen	☐ Community Detention
☐Special Humanitarian Visa	☐Temporary Visa	☐ Bridging Visa (with SRSS case manager)
☐Visa 866		☐ 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**

Referral Information & Indicators (*Will be used to determine eligibility and triage accordingly***)**

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

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

Person discloses experience of torture or other traumatic events with or without prompting.	☐
Note:	
Person discloses injuries or pain which is/are the result of torture, sexual assault or other form of violence.	☐
Note:	
Person discloses suicidal ideation or self harm [**Note**: Please refer to an emergency service if an immediate risk]	☐
Please Specify:	
Person is seeking referral as a result of family relationship difficulties.	☐
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	☐	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	☐	Risk-taking behaviours	☐
Poor memory / concentration	☐	Persistent headaches or other aches	☐
Alcohol or substance abuse	☐	Poor peer relationships	☐
Poor self care, household care	☐	Very clingy behaviour of children	☐
Persistent physical ailments with no medical cause e.g. headaches, neck pain, stomach pain	☐	Alcohol or substance abuse (especially for adolescents)	☐
Not responding to needs of children, emotional distance	☐	Frequent tantrums	☐
Persistent and severe sleep difficulties/ nightmares	☐	Overacting to minor incidents	☐
Signs of family conflict	☐	Expressed threat to harm self or others *	☐
Person appears disoriented, incoherent or confused	☐	Bizarre behaviours Specify:	☐
Person expresses bizarre or illogical belief Specify:	☐		
Expressed threat to harm self or others *	☐		☐
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)			☐
Intellectual / Cognitive impairment: suspected ☐ assessed ☐ confirmed ☐ Details:			
*** 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**			

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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