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.

When there is an immediate risk of harm to self or others, please refer to an emergency service or call 000.

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

All referrals are discussed at QPASTT's weekly referral meeting

Please complete one form per person.

Client Details:

Date:

Name:

Address:

Telephone: Mobile:

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

Date of Birth: Country of Birth: Ethnicity:

Preferred Language/s: Interpreter Required Yes ☐ No ☐

Interpreter Preferences:

Referrer Details:

Name of Worker: Referring Organisation:

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

Telephone: Mobile:

Email Address:

Visa Status:

Permanent Visa: ☐ Temporary Visa: ☐ Persons Seeking Asylum: ☐

Date of Arrival:

Family Information:

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

Number of family members living with you: ☐

Please list all family members including how they are related to you:

Given Name	Surname	Date of Birth	Gender	Relationship to you

Referral Information:

What help do you require? Individual Counselling ☒ Family Counselling ☐Group Work ☐

Details:

Please tell us how you are feeling

I often feel sad or cry a lot	☐
I sometimes feel very angry	☐
I have family relationship difficulties	☐
I have difficulties falling asleep	☐
I can't stay asleep and have bad dreams	☐
I feel scared /fearful to go to work/school/out	☐
I worry a lot of the time	☐
I have stomach and body aches with no medical reason	☐
I cannot concentrate and forget things	☐
I sometimes think about hurting myself or someone else	☐

Is there anything else you would like to tell us about your feelings and/or situation:

_____

_____

_____

_____

_____

Supports:

Could you please let us know if there are any other people and/or services supporting you at the moment? Are you attending school? If you are, which school please give us the name of the school.

_____

_____

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

Agency/Education Centre: Name of Worker/Teacher:

_____

Contact Number/s:

_____

Email Address:

_____