QPASTT is not a crisis service and is unable to respond immediately. When there is an immediate risk or harm to self or others, please refer to an emergency services or call 000

Self-Referral Form

***Eligibility**: Refugee experience prior to arrival (persecution, war, violence, torture) and are experiencing psychological and psychosocial difficulties. Children & Youth with parents/carers from refugee background.*
For further information or questions on eligibility and on QPASTT's programs, visit QPASTT website www.qpastt.org.au or please contact QPASTT Main Office: Phone: +61 (07) 3391 6677

Please complete one form per person (Self-Referral Form)

REFERRAL Details					
Referral Date		Referring Organisation name			
Referrer Name					
Telephone		Mobile			
Email address			Fax		
Organisation Address			Post Code		

Details for Person being Referred (Client details)			
Family Name			
Given Name			
Date of Birth (DD/MM/YY - If exact date not known, please give any information available)		Gender ☐ Female ☐ Male Prefer to self-describe	
Address		Post Code	
Mobile		Home Telephone	
Email address			
Is there any information that would help us to contact you (eg: contact after 2pm or text before phoning)			
Date of Arrival in Australia (DD/MM/YY – If exact date not known, please give any information available)		Country of Birth	
Ethnicity		Preferred Language/s	
Interpreter required ☐ Yes ☐ No		Interpreter preference	☐ Female ☐ Male ☐ No preference
Migration Visa Status ☐ Permanent Visa ☐ Temporary Visa ☐ Australian Citizen ☐ Person seeking Asylum ☐ Bridging Visa			
What help do you require: ☐ 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:

Total number of family members living with you	

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

Given name	Surname	Date of birth	Gender	Relationship to you

Please indicate here if you have concerns about any of the above family members

Could you please let us know if there are any other people supporting you at the moment (eg: family, friends, etc) ? Are you attending school? If you are, which school– please give us name of the school

Other current agencies /workers such as GPs, Schools, TAFE, Including NDIS, etc involvement including Contact person/s and contact details

Agency Name		Contact person	
Email address		Contact number/s	
Agency Name		Contact person	
Email address		Contact number/s	

Thank you for taking time to complete this referral.

Click here to submit this referral form via email or save this form and email to referral@qpastt.org.au