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

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 **(* denotes compulsory fields to be completed)**

REFERRAL SOURCE (Details of Referring Person/ Organisation)	*Referral date	
Self- Referral ☐ Yes ☐ No	☐ I am the person being referred	
☐ I am authorised to complete the referral on behalf of the person being referred Please provide below your name, contact details and relationship to the person being referred.		

Please complete below Referring Organisation details only if this is not a Self Referral

*Referrer Name			
*Referring Organisation Name			
*Referrer Contact Phone		Mobile	
*Referrer Email address		Fax	
Referring Organisation Address		Post Code	

Consent is essential for all QPASTT services

*Has the client consent to this referral ☐ Yes ☐ No **"We cannot accept a referral without consent"**

*If the person is under 18 years old, has a parent / carer provided consent to this referral ☐ Yes ☐ No ☐ NA

If no, Please provide some more details below. QPASTT will explore this further during the Intake process.

*Can the client be contacted directly ☐YES ☐NO If No, Please provide other contact details below:

Name of Carer / Parent / Worker
Contact details of Carer/Parent/ Worker:

Details for Person Being Referred. Please complete one form per person being referred

*Family Name		*Date of Birth (DD/MM/YYYY, *If exact date not known, please provide any information available)*	
*Given Name			

*Gender : ☐ Female ☐ Male ☐ Non-binary ☐ Transgender Female ☐ Transgender Male

Prefer to self-describe:

Address		*Post Code	
*Mobile		Home Telephone	
Email address			
Is there any information that would help us to contact this person *(e.g. Consideration around risks of DV, contact after 2pm, or send text message before calling)*			
Date of Arrival in Australia *(DD/MM/YYYY, If exact date not known, please provide any information available)*		*Country of Birth	
Ethnicity		Faith identity	

*Preferred Language/s

*Interpreter required ☐ Yes ☐ No If yes, Interpreter preference ☐ Female ☐ Male ☐ No preference

Provide any further details regarding interpreters here

If this person attends School, School Name		Year/Grade	

*Has this person been in immigration detention ☐Yes ☐No ☐Unknown

If yes, Date of release from immigration Detention
Places of immigration Detention

What Social supports does this person have in Australia:

*Migration Visa Status: ☐ Asylum Seeker ☐ Australian Citizen ☐ Permanent Resident ☐ Temporary Humanitarian ☐ Temporary Visa ☐ Unknown ☐ Other

Migration Visa SubClass

☐ Refugee Visa (Subclass 200)	☐ Bridging Visa E (Subclass 050-051)	☐ Protection Visa (Subclass 866)
☐ In-Country Special Humanitarian Visa (Subclass 201)	☐ Bridging Visa E – Final Departure BVE	☐ Temporary Protection Visa (Subclass 785)
☐ Global Special Humanitarian Visa (Subclass 202)	☐ No Visa – Finally Determined	☐ Safe Haven Enterprise Visa SHEV (Subclass 790)
☐ Woman at Risk Visa (Subclass 204)	☐ No Visa – Community Detention	☐ Visitor Visa
☐ Humanitarian Stay Temporary Visa (Subclass 449)	☐ No Visa – In Detention Centre	☐ Student Visa

☐ Other

Total number of family members living under the same roof as this person (including person being referred):

Relationships to the person being referred (e.g. spouse, Child, Sibling, Grandmother, flatmate):

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

*Program this person is being referred to (select at least one)

☐ Counselling Programs	☐ Youth Programs	☐ Group Programs

☐ Asylum Seeker Mental Health Connect (assessment & brief intervention) (for asylum seekers, TPV or SHEV holders only)

☐ Other

Please tell us why you are referring to QPASTT at this time and how you hope QPASTT may be able to assist:

*Please select and describe if any of the following present:

☐ Person discloses experience of torture or other traumatic events with or without prompting.

Details:

☐ Person discloses injuries or pain which is/are the result of torture, sexual assault or other form of violence.

Details:

☐ Person discloses suicidal ideation or self-harm [Note: Please refer to an emergency service if there is an immediate risk of harm to self or others] For non-immediate threats, please provide further details*

Details:

☐ Person is seeking referral as a result of family relationship difficulties.

Details:

Trauma, Health and Disability information: *A possible question to ask about torture and trauma: "Some people have had bad things happen to themselves and their families. Has anything happened to you or your family that is affecting the way you are feeling now?"* ***Please select at least one:***

Adults / Adolescents / Children		**Additional considerations for Children / Adolescents only**	
☐	Anxiety and/or depression	☐	Very clingy behaviour of children
☐	Severe Social withdrawal	☐	Early disengagement from school / school refusal
☐	Severe sleep difficulties and/or nightmares	☐	Poor peer relationships
☐	Loss of appetite/sudden weight loss or weight gain	☐	Difficulties at school with learning and/or participation
☐	Difficulty with controlling emotions & behaviour(e.g. crying a lot, tantrums in children)	☐	Regression in behaviour (e.g. reduced independence in regular tasks)
☐	Difficulties with concentration or memory	☐	Delays in development (e.g. failure to thrive)
☐	Aggressive behaviour or persistent anger	☐	Risk taking behaviour
☐	Recent death of a loved one	☐	Re-enactment of trauma in play/art/stories
☐	Poor Care for self or family	☐	Child safety concerns (for children and youth)
☐	Domestic / Family violence	☐	Bed wetting
☐	Sexual assault		
☐	Concerns about alcohol or substance abuse		
☐	Concerns about gambling		
☐	Other – please specify:		
☐	Learning difficulty /Cognitive impairment ☐ suspected ☐ assessed ☐ confirmed Details:		
☐	Physical disability and/or Chronic illness ☐ YES ☐ NO Details:		

Please provide details of any other workers/agencies supporting this person (other than the referring agency): Including NDIS & the type of support provided.

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

Thank you for taking time to complete this referral. Please submit this form only after completing the required fields marked with asterisk (*)

Please click here to submit this referral via email to referral@qpastt.org.au