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|  | **ASeTTS Referral Form****ASSOCIATION FOR SERVICES TO TORTURE & TRAUMA SURVIVORS** | Please send this form by email (referral@asetts.org.au) or fax (08 9227 2777) to ASeTTS. Note: ASeTTS is not a crisis service. If a client needs urgent aid, contact Lifeline (13 11 14). |

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| **REFERRAL GUIDELINES**  |  |
| * **Refugee-like background** - person left their country of origin due to fear or actual persecution on the basis of race, nationality, ethnicity, religion, sexuality, political or other affiliations.
* **Torture and trauma experiences** – person has been affected by trauma, including violent conflict, imprisonment, torture, multiple losses, forced migration and family separation.
* **Trauma-related psychosocial symptoms** – including, intrusive memories, difficulties sleeping or concentrating, negative moods or emotions, relationship difficulties and hyper-vigilance.
 | [ ] [ ] [ ]  |

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|  | Date of Referral:  |       |

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| **CLIENT DETAILS**  |
| Surname:  |       | Given Name/s: |       | D.O.B.: |       |
| Gender: | [ ]  Female [ ]  Male [ ]  Other  | Marital status: |       | No. Children: |       |
| Address:  |       | Suburb: |       | Postcode: |       |
| Phone: |       | Mobile: |       | Email: |       |
| Interpreter needed:  |  [ ]  Yes [ ]  No [ ]  Unsure  | Preferred Language/s: |       |
| **Does the client have a ‘refugee-like background’:** | [ ]  Yes [ ]  No [ ]  Unsure  |
| Residential Status: [ ]  Aus. Citizen [ ]  Permanent Res. [ ]  Temp. Humanitarian Visa [ ]  Asylum Seeker [ ]  Other |
| Country of Birth:       | Date of Arrival:       | Visa Subclass:       |
| Settlement or Asylum Seeker Service Agency (if app.):       |

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| **REFERRER DETAILS** |
| Name: |       | Organisation: |       |
| Address:  |       | Suburb: |       | Postcode: |       |
| Phone: |       | Mobile: |       | Email: |       |

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| **REASON FOR REFERRAL** |
| Describe:       |

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| **SERVICE RECOMMENDATION** |
| [ ]  | Individual Counselling | [ ]  | Youth Counselling | [ ]  | Family Counselling |
| [ ]  | Community & Social Group | [ ]  | Other:       | [ ]  | Other:       |

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| **CLIENT CONSENT & HELP-SEEKING** |
| Has the client or their guardian given consent to be contacted by ASeTTS?  | [ ]  Yes  | [ ]  No  |

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| **ELIGIBILITY OF CLIENT** |
| **Has the client experienced or witnessed torture and/or trauma:**  | [ ]  Yes [ ]  No [ ]  Unsure  |
| Describe:       |
| **Does the client have trauma-related stress symptoms:** |  [ ]  Yes [ ]  No [ ]  Unsure  |
| [ ]  | Feeling sad and/or hopeless | [ ]  | Feeling angry and/or irritable | [ ]  | Feeling afraid and/or anxious |
| [ ]  | Difficulty sleeping | [ ]  | Difficulty concentrating | [ ]  | Unpleasant memories |
| [ ]  | Social isolation or avoidance | [ ]  | Body pain and/or fatigue | [ ]  | Other:       |
| Describe other symptoms:       |

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| **PARENT/CARER DETAILS (if client is below 15 years of age)** |
| Name: |       | Relationship: |       |
| Address:  |       | Suburb: |       | Postcode: |       |
| Phone: |       | Mobile: |       | Email: |       |

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| **ADDITIONAL INFORMATION** |
| **Does the client have mental health or cognitive issues:**  |  [ ]  Yes [ ]  No [ ]  Unsure  |
| Describe:      |
| **Does the client have physical health or disability issues:** |  [ ]  Yes [ ]  No [ ]  Unsure  |
| Describe:      |
| **Does the client have settlement Issues:**  |  [ ]  Yes [ ]  No [ ]  Unsure  |
| Describe:      |
| **Are there any relevant risk or protection issues:** |  [ ]  Yes [ ]  No [ ]  Unsure  |
| Describe:      |
| **Other relevant information (incl. additional service providers):** |  [ ]  Yes [ ]  No [ ]  Unsure  |
| Describe:      |

 **Thank you for referring to ASeTTS. You can expect a response within ten (10) days.**

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| **ASeTTS OFFICE USE ONLY** |
| Date received: |       | Received by: |       | CRM No. (if app.) |       |
| Date reviewed: |       | Reviewed by: |       | Added to CRM:  |       |
| Review outcome: | [ ]  Accepted [ ]  Not Accepted  | Authorised by  |       |
| Review notes:       |