CONFIDENTIAL

Referral to STARTTS Counselling

STARTTS services are available to people from refugee and refugee-like backgrounds with a history of torture and trauma prior to arrival in Australia, who are experiencing psychological / psychosocial difficulties believed to be associated with their experience of torture and trauma. Please contact STARTTS Intake for more information.

Email: STTS-IntakeGeneral@health.nsw.gov.au **Phone:** (02) 9646 6800 **Fax:** (02) 9646 6801

STARTTS is not a crisis service.

For urgent assistance, please contact Lifeline on 13 11 14 or the Mental Health Line on 1800 011 511.

Items marked * are mandatory to our referral processes. If the item is unknown or not applicable, please specify as such.

REFERRER DETAILS		
* Date:	* Referring Organisation:	
* Name:	*Email:	
Address:		
* Contact number (main):	Fax number:	
CONSENT (verbal consent sufficient)		
* Has the client consented to the referral to STARTTS?	☐ Yes	☐ No
* If the client is under 14, has parental/carer consent been obtained?	☐ Yes	☐ No
CLIENT INFORMATION		
* Family Name:	* Given Name:	
* Gender: M F Client Identified:	Please Specify:	* DOB:
Marital Status: ☐ Never Married ☐ Married ☐ De facto ☐ Separated ☐ Divorced ☐ Widow ☐ Unknown		
* Street Address:	* Suburb:	
* Postcode:	Email:	
* Main Number:	Other Number:	
* Country of Birth:	Ethnicity:	Religion (Optional):
* Interpreter Required: ☐ Yes ☐ No	* Preferred Language:	
* Interpreter gender preference: ☐ M ☐ F ☐ Either	* Counsellor gender preference: ☐ M ☐ F ☐ Either	
Person to Contact:	Relationship to Client:	
Contact Number:	Interpreter Required: ☐ Yes ☐ No	Preferred Language:

* RESIDENTIAL STATUS				
*Date of Arrival:	☐ Australian Citizen	* Visa Subclass Number: (For Permanent Residents, Asylum Seekers and Temporary Visa holders)	Date Visa Granted:	
			Detention in Australia? Type:	
			Place:	Duration (months):
Permanent Resident Temporary Visa SHEV TPV Other__________				
☐ Asylum Seeker ☐ BV ☐ CD	SRSS/HSP Agency:	*Boat ID:	*CID ID:	

If you run out of space for any of the following questions, please proceed to Page 3 to include further information.

*** REASONS FOR REFERRAL – Main presenting problem(s) and symptoms (if known)**

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HISTORY OR PRESENCE OF THE FOLLOWING ISSUES – Adults / Children / Adolescents (In accordance with the information you have obtained from a client-CHECK ALL THAT APPLIES). + Please provide details below. The information will be used in the client allocation process.

+Suicidal ideation or attempt	Past	Current	Intense/persistent feelings of guilt
+Threat to harm others/homicide	Past	Current	Crying often
+Mental Health - Admission to hospital	Past	Current	Continuously worrying
+Mental Health crisis team	Past	Current	Intense/persistent emotional distress
+Alcohol or substance abuse	Past	Current	Loss of appetite/sudden weight loss or weight gain
+Sexual assault	Past	Current	Repeated expressions of hopelessness
+Family and/or Relationship difficulties	Past	Current	Social withdrawal or seems distanced
+Family / Domestic violence	Past	Current	Persistent and severe sleep difficulties and/or nightmares
+Bizarre or illogical beliefs			Aggressive behaviour or persistent anger
+Appears disoriented, incoherent or confused			Phobias (e.g. fear of going out/fear of groups)
+Physical health issues and/or disabilities			Difficulties with concentration and /or memory
+Grief and loss reactions			+Headaches or any other Physical Pain

For criteria with a + please provide further details:

ADDITIONAL CRITERIA FOR CHILD/ADOLESCENT CLIENTS ONLY

+Parent/carer issues (e.g. marital problems, financial difficulties, mental health)	+ Child/Young person is at risk of harm and/or child protection concerns
+Risk-taking behaviour	Re-enactment of a traumatic event in play
"Out of control" behaviour	Frequent tantrums
Not wanting to go to school, poor school attendance	Clinging behaviour
Bed wetting	Over-reacting to noises or other environmental stimuli
Persistent lack of expression of positive emotions	Failure to thrive

For criteria with a + please provide further details:

SUPPORT NETWORKS

Agency	*Name*	*Phone*	*Email*

***SCHOOL DETAILS FOR CHILD/ADOLESCENT**

School Name: | Suburb:

Year/Class | Contact person at School:

Contact Number: | Email:

Position: ☐ Classroom Teacher ☐ ESL Teacher ☐ School Counsellor ☐ Other, please specify:

For any questions regarding completion of this form, please call **(02) 9646 6800**.
Email completed form to **STTS-IntakeGeneral@health.nsw.gov.au** or fax to **(02) 9646 6801**

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FURTHER INFORMATION

STARTTS OFFICE USE ONLY

☐ HSS	☐ Non-HSS	☐ CD	☐ A/S	☐ SRSS	☐ Non-SRSS	Priority:	MRN
☐ C&A	☐ Re-Ref	☐ R&R	Preliminary Assessment Yes			Intake Counsellor	Intake Data Entry

Risk	Yes	No	ND	Risk	Yes	No	ND	Received by:	Entered By:
Suicide				Child at Risk				Date received:	Date received:
DFV				Crisis				Date letter sent:	Date entered:

Notes (incl TIS Job No.):

Note: ND – Not Disclosed