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CONFIDENTIAL

ADULT Referral to Phoenix Centre Services

Phoenix Centre services are available to people from a refugee background 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 the Phoenix Centre for more information.

SERVICE REQUIRED

☐ ***Counselling (North and South)*** ☐ ***Natural Therapies (South only)***

The Phoenix Centre is not a crisis service and is not able to respond immediately.

For urgent assistance, please contact Lifeline on 13 11 14 or the Mental Health Helpline on 1800 332 388)

REFERRER DETAILS (fields marked with an * must be completed)

* Date: _____ Referring Organisation: _____

* Name of referrer: _____ Email: _____

* Contact number (main): _____ Contact number (other): _____

CLIENT INFORMATION (fields marked with an * must be completed)

* Family name/s: _____ * Given name/s: _____

* Gender: ☐ Female ☐ Male ☐ Transgender ☐ Other: _____ * Date of birth: _____

* Full address: _____

* Main number: _____ Additional number: _____

Best time to phone: ☐ AM ☐ PM ☐ Any Email: _____

* Date of arrival: _____ * Country of birth: _____

Ethnicity/religion: _____ * Preferred language/s: _____

* Interpreter required: ☐ Yes ☐ No * Interpreter gender: ☐ Female ☐ Male ☐ Either

RESIDENTIAL STATUS

Permanent Resident: ☐ Yes ☐ No Visa type: _____

e.g. (humanitarian, Woman at Risk 204)

Australian Citizen: ☐ Yes ☐ No

Asylum seeker: ☐ Community detention ☐ BVE ☐ Other: _____

Support agency: _____ DIBP boat ID: _____ DIBP client ID: _____

Temporary visa: ☐ TPV ☐ SHEV ☐ Other: _____

FAMILY MEMBERS RESIDING WITH CLIENT

Name/Relationship	*Age*	*Gender*	*Are you concerned about this person?*
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

REASONS FOR REFERRAL (please attach additional page if necessary)

Main presenting problem(s) and symptoms (if known):

Please tick and describe if any of the following are present:

Person discloses experience of torture or other traumatic events.	☐	Comments
Person discloses injuries or pain which is/are the result of torture, sexual assault or other form of violence.	☐	Comments
Person discloses suicidal ideation or self harm [Note: Please refer to an emergency service if an immediate risk]	☐	Comments
Person is seeking referral as a result of family relationship difficulties	☐	Comments

Psychological screening: Observations (no questions required) or spontaneous disclosures of

History or presence of the following issues (check all that apply):

- ☐ Crying a lot
- ☐ Aggressive behaviour or persistent anger
- ☐ Repeated expressions of hopelessness
- ☐ Severe social withdrawal or appears uncommunicative
- ☐ Peculiar appearance, behaviour or speech
- ☐ Not responding to needs of children, emotional distance
- ☐ Persistent physical ailments with no medical cause
- ☐ Persistent and severe sleep difficulties, nightmares
- ☐ Appears disoriented, incoherent or confused
- ☐ Intense/persistent emotional distress
- ☐ Phobias: e.g. fear of going out/fear of groups
- ☐ On alert for things going wrong
- ☐ Overreacting to noises, etc. in environment
- ☐ Alcohol or substance abuse
- ☐ Poor self-care, household care
- ☐ Signs of family conflict
- ☐ Expressed threat to harm self or others
- ☐ Expresses bizarre or illogical beliefs

Person or family member discloses that he/she suffers from a mental health problem or that he/she is being treated for a mental health problem (or their words for this)	Y/N
Intellectual / Cognitive impairment : suspected ☐ assessed ☐ confirmed ☐ Details:	
Where there is an immediate risk of harm to self or others please refer to emergency service. For non-immediate threats, please provide a description below:	

Please describe in detail anything selected above including any identified risks to self or others:

Please specify what supports/strategies have been used in an attempt to support this person

SUPPORT NETWORKS (e.g. community group, school, and other agency)

Agency/organisation/school/GP	*Contact name*	*Contact number*

CONSENT (essential for all Phoenix Centre services)

Has the client given consent to be contacted by the Phoenix Centre?	☐ Yes	☒ No
Can the client be contacted directly?	☐ Yes	☒ No
Has the client given consent for the Phoenix Centre to contact the referrer?	☐ Yes	☒ No

Client signature: _____

Referrer signature confirming Verbal Consent has been received via TIS: _____

For any questions regarding completion of this form, please call **03 6221 0999**

For both North and South referrals, email completed form to **phoenixreferrals@mrctas.org.au**