Version: August 2016

CONFIDENTIAL

Referral to Phoenix Centre Services

phoenix centre
support for survivors of torture and trauma

People eligible to access Phoenix Centre and/or PHaMs (Personal Helpers & Mentors) services include those who have a refugee background and a history of torture and trauma prior to arrival in Australia, and who are experiencing psychological or psychosocial difficulties believed to be associated with their experience of torture and trauma. Please see Phoenix Centre website for more information

SERVICE REQUIRED

☐ ***counselling*** (North and South) ☐ ***mentoring*** (South only) ☐ ***natural therapies*** (South only)

(The Phoenix Centre is not a crisis service. 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: ___ / ___ / _____

* Address: _____

* Mobile number: _____ Home 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 citizen: ☐ Yes ☐ No Visa type: _____
e.g. (humanitarian, Woman at Risk 204)

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

Office use only - MRN: Counsellor:

Current severity or risk for the client (1 = low, 4 = high): ☐ **1** ☐ **2** ☐ **3** ☐ **4**

REASONS FOR REFERRAL (please attach additional page if necessary)

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

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

Additional criteria, for child/adolescent clients:

- ☐ Risk-taking behaviour
- ☐ Out of control behaviour
- ☐ Not wanting to go to school, poor school attendance
- ☐ Failure to thrive
- ☐ Re-enactment of a traumatic event in play
- ☐ Bed wetting
- ☐ Frequent tantrums
- ☐ Very clingy behaviour

Please describe in detail anything selected above:

SUPPORT NETWORKS (e.g. community group, school, 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
If the client is under 14, has parental/carer consent been obtained?	☐ 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: _____

For any questions regarding completion of this form, please call **03 6234 9138**

For both North and South referrals, email completed form to: **phoenixreferrals@mrchobart.org.au**
or post to: **PO Box 259, Glenorchy 7010**

NOTE: *As confidentiality cannot be guaranteed, faxed referrals are* ***strongly*** *discouraged*