PAST program referral form (child)

Prevention, Assessment, Support and Treatment (PAST) of harmful sexual behaviours

This form is for the use of professionals or carers. For self-referrals please phone us (03) 6231 0044 during business hours for direct support from our friendly team.

If you have experienced sexual violence or harm in the past 7 days, please call the SASS 24/7 Helpline (1800 697 877) for immediate information and support.

This form is to be used for referrals to SASS' Prevention, Assessment, Support and Treatment of harmful sexual behaviours program.
Other referral forms are available from www.sass.org.au/make-a-referral;

- Adult Counselling program and Redress Support Service.
- General Children and Families Counselling Service.
- Forensic Therapeutic program.

SASS has eligibility criteria for all programs. Thank you for providing as much detail as possible. The information you share helps the intake team manage demand for our services. If you are unsure whether your referral is appropriate, please contact us to discuss.

Date of referral:

Month Day Year

Referring person or agency:

Referrer relationship to client:

Referrer email:

example@example.com

Referrer phone number:

Please enter a valid phone number.

Has the client consented to this referral being made?

- ○ Yes
- ○ No

Who is this referral for?

- ☐ A Child/Young Person
- ☐ An Adult/Guardian

Has the client accessed SASS previously?

- ○ Yes
- ○ No
- ○ Unknown

Is client aware that the PAST program is delivered by SASS in conjunction with Mission Australia and information may be shared across these two agencies?

- ○ Yes
- ○ No
- ○ Unknown

When responding to this referral, who should we first make contact with?

- ○ Referrer
- ○ Young Person
- ○ Primary Carer

How did the referrer/the client hear about SASS?

- ☐ Child Safety Service
- ☐ Internet Search
- ☐ Interstate service
- ☐ NDIS/Disability Service
- ☐ Police/Legal/Justice
- ☐ Redress Scheme/ Knowmore
- ☐ Other
- ☐ Advice and Referral Line
- ☐ Social Media
- ☐ Medical Practitioner/ Health Service
- ☐ NGO service
- ☐ Psychologist/ Counsellor
- ☐ Is your referral a result of contact with Primary Care Family and Sexual Violence Support?

Name

First Name Last Name

Gender

- ☐ Female
- ☐ Transgender
- ☐ Male
- ☐ Non-binary

☐ Prefer not to say

Preferred pronouns:

◯ He/Him/His
◯ She/Her/Hers
◯ They/Them/Theirs
◯ Prefer not to say
◯ Other

Date of Birth

Month Day Year

Current school (if attending):

Cultural identity:

☐ None
☐ Aboriginal and Torres Strait Islander
☐ Aboriginal
☐ Torres Strait Islander
☐ Prefer not to say
☐ Other

Does the client have a disability or any additional needs?

☐ Cognitive
☐ Physical
☐ None
☐ Prefer not to say
☐ Other

Does the client have any other known or suspected diagnoses?

☐ AttentionDeficit Hyperactivity Disorder (ADHD)
☐ Autism Spectrum Disorder (ASD)
☐ None
☐ Prefer not to say
☐ Other

Residential address

Town/Suburb State

Is it safe to send hard copy mail to this address?

- Yes
- No

Postal address

- Same as residential address

Street Address

Street Address Line 2

Town/Suburb State

Post Code

Is it safe to send hard copy mail to this address?

- Yes
- No

Emergency contact name:

First Name Last Name

Relationship to client:

○ Tick here is this is Parent/carer/guardian referral and continue to the 'Referral details' section.

Name:

First Name Last Name

Phone:

Area Code Phone Number

Email:

example@example.com

Relationship to client:

Is the primary contact aware of all information on this referral form?

○ Yes
○ No

Is the client living with the primary contact?

○ Yes - (full-time)
○ Yes– Shared Care (part-time)
○ Other

Who else is the client residing with?

Will this person be organising the appointments at SASS?

- ◯ Yes
- ◯ No
- ◯ Unknown

Who is the client's legal guardian?

- ◯ Parent
- ◯ Child Safety Service (CSS)
- ◯ Unknown
- ◯ Other

If CSS, provide name and contact details:

First Name Last Name

CSS phone Number

Please enter a valid phone number.

CSS email

example@example.com

Are there current Legal Orders in place:

- ◯ Child Protection
- ◯ Family Court
- ◯ Other

Please provide details of the problem/harmful sexual behaviour:

What happened, frequency, duration, escalating/deescalating, evidence of coercion, context –home, respite, school etc.

What was the client's response when the behaviour was discovered?

What was the family's reaction to this behaviour?

Minimizing, denying, wanting to get client help?

Was the behaviour targeted towards someone else?

- ◯ Yes
- ◯ No
- ◯ Unknown

Please list any young people who have been impacted by these behaviours (victims) including age and gender (if known):

This information is collected to help us identify and manage any safety, privacy and scheduling concerns that may arise if both young people are accessing the service.

Is there any other non-sexual behaviour the client has or is engaging in? If so please describe:

E.g. criminal, antisocial etc.

Please provide a brief summary of the family history/dynamics, including key relationships for the client in the family:

Has the client experienced or witnessed Family Violence?

- ◯ Yes
- ◯ No
- ◯ Unknown

If yes, is this:

- ◯ Current
- ◯ Historic

Has Child Protection Notification been made in relation to HSB?

- ◯ Yes (please provide details below)
- ◯ No
- ◯ Unknown

Name of ARL/CSS worker:

Name if known.

ARL/CSS reference number:

Refernce number if known.

Have police been made aware of this matter?

- ◯ Yes
- ◯ No
- ◯ Unknown

What are the client's strengths, current coping strategies and support network?

Include social and professional supports

What support does the client need from SASS?

E.g. counselling, court support, police report

Are there any additional factors that have led to the client seeking a referral?

Does the client need support to access SASS?

E.g. disability, interpreter, support person, medical, cultural, anxiety/mental health, etc.

Are there any indications for safety issues for SASS workers with the client?

E.g. anger issues, psychosis, client views worker as threat etc.

Who will be the main contact for the client to book appointments with?

- ☐ The client
- ☐ Legal guardian
- ☐ CSS
- ☐ Other

What are the best times/days for SASS appointments?

What are the preferred modalities for SASS appointments?

- ☐ Face to Face
- ☐ Video call
- ☐ Phone call
- ☐ Combination

Does the client have reliable access to internet and technology?

- ○ Yes
- ○ No

Does the client prefer a counsellor of a particular gender?

- ☐ Female
- ☐ Male
- ☐ Either
- ☐ Unknown

Referral taken by (SASS representative):

What is identified as the primary need for support?

- ☐ Brief intervention
- ☐ Comprehensive counselling service
- ☐ Group / Wellbeing Program
- ☐ Trauma-informed parenting support for the client's guardian

Once completed, save this referral form to your files, then upload via the secure PDF upload www.sass.org.au/make-a-referral. Do not email this referral form directly to us.

Sexual Assault Support Service
114 Bathurst St, Hobart, 7000
Phone: (03) 6231 0044
24/7 MY SUPPORT: 1800 697 877

SASS

Submit