

## Forensic Therapeutic Program referral form

Including individuals subject to Community Orders/Parole

**This form is for the use of professionals or carers. For self-referrals please phone us (03) 6234 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.**

Once completed, save this referral form to your files, then upload via the secure PDF upload <https://www.sass.org.au/forensic-therapeutic-program>. **For security reasons, do not email this referral form directly to us.**

This form is to be used for referrals to SASS' **Forensic Therapeutic program**.

Other referral forms are available from <https://www.sass.org.au/make-a-referral>:

- Adult Counselling program and Redress Support Service.
- General Children and Families Counselling Service.
- Prevention, Assessment, Support and Treatment of harmful sexual behaviours 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

**If the client is currently incarcerated, when is their expected release date:**

**If the client is currently incarcerated, what area and/or address will they be released to:**

(e.g. Hobart, Devonport, West Coast)

**Has the client ever been charged or convicted with offences of a sexual nature?**

No

Yes (provide details below)

**If yes, please specify:**

Date, year, sentence etc.

**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 indicated they are wanting support regarding their experience of sexual harm?**

Yes

No

**Has the client consented to this referral being made?**

Yes

No

**Has the client accessed SASS previously?**

Yes

No

Unknown

**Is the client a participant of the National Redress Scheme:**

Yes  
No  
Unknown

**How did the referrer/the client hear about SASS?**

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

**Name**

First Name      Last Name

**Date of Birth**

Month   Day   Year

**Gender**

|                   |            |
|-------------------|------------|
| Female            | Male       |
| Transgender       | Non-binary |
| Prefer not to say |            |

**Preferred pronouns:**

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

**Cultural identity:**

- None
- Aboriginal and Torres Strait Islander
- Aboriginal
- Torres Strait Islander
- Prefer not to say
- Culturally and linguistically diverse background

**Please specify:**

Cultural and linguistic background.

**Does the client have a disability, or any other mental and/or physical health presentations?**

- Yes
- No
- Prefer not to say
- Not known

**If yes, please specify:**

**Does the client have any literacy limitations:**

- Reading difficulties
- Writing difficulties
- Unable to read or write
- Prefer not to say
- Not known
- Other

**Is the client subject to any Family Violence Orders?**

- Yes
- No

**If yes, please provide details including date of expiry and any exclusions/restrictions on areas/people:**

This information will help us assess for conflicts of interest.

**If the client is subject to a Community-based Order, please specify:**

Community Service  
Community Corrections Order  
Home Detention  
Court Mandated Diversion and Drug Treatment Order  
Parole  
Other

**Please provide Community-based Order details:**

E.g. offending type, sentence length, expected date of discharge, reporting obligations, restrictions (and/or a copy of their Order attached to this referral, below).

**If the client is currently in prison, where are they housed?**

Ron Barwick Minimum Security Prison  
Risdon Prison Complex  
Mary Hutchinson Women's Prison  
Hobart Reception Prison  
Southern Remand Centre  
Other

**Current sentence details:**

E.g. offending type, sentence length, earliest release date, parole eligibility date.

**Other (please indicate):**

E.g. on bail, pre-sentencing, charged but not convicted, transferring from juvenile justice, high risk of entering system.

**Has the client engaged in any mental health, rehabilitative, or other treatment programs/groups?**

No

Other

**What are the client's key difficulties at present?**

I.e., mental health; self-harm; drug & alcohol; homelessness; depression; hallucinations; flashbacks; self-regulation; delusions; etc. Please include frequency, duration and severity of symptoms/behaviours.

**Is this a first disclosure?**

Yes

No

Unknown

**Please provide any relevant information regarding sexual assault history if possible:**

E.g. historical, current, ongoing, single or multiple instances etc.

**Are there any safety issues for the client?**

I.e. threat of further sexual assault/abuse, etc

**What is the client's support network?**

**What are the client's strengths/ current coping strategies?**

**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.

**What is the best time/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

**What support is the client hoping to access**

- Trauma specific therapeutic support related to prior sexual harm
- Redress Support
- Unsure
- Other

**Does the client prefer a counsellor of a particular gender? (We will do our best to accommodate preferences wherever possible.)**

- 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
- Redress Scheme



Once completed, save this referral form to your files, then upload via the secure PDF upload <https://www.sass.org.au/forensic-therapeutic-program>. For security reasons, 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

