

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) 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.

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.

*If you are using the PDF version of this form, save the completed 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. 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

Prefer not to say

Male

Non-binary

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

Street Address

Street Address Line 2

Town/Suburb

State

Post Code

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 if 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?

Embarrassment, defensiveness, withdrawal etc.

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:

E.g. grandfather, mother, siblings etc. Are these relationships and connections seen to be positive?

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:

Reference 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 <https://www.sass.org.au/prevention-assessment-support-and-treatment-past-of-harmful-sexual-behaviours>. 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

