Sexual Assault Support Service

Children and Families Counselling Program

Referral Form

This form is for the use of professionals or service providers. For self-referrals or families, 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.

Once completed, save this referral form to your files, then upload via the secure PDF upload https://www.sass.org.au/make-a-referral-children-and-families. **For security reasons, do not email this referral form directly to us.**

This form is to be used for referrals to SASS' **General Children and Families Counselling Service**. This program supports young people directly impacted by sexual harm and/or the family supporting them. For support for young people engaging in risky or harmful sexual behaviour please make a referral to the **Prevention, Assessment, Support and Treatment of Sexual Behaviours program**.

Other referral forms are available from www.sass.org.au/make-a-referral;

- Adult Counselling program and Redress Support Service.
- Forensic Therapeutic program.
- 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:

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

- ◯ Yes
- ◯ No

Has consent been given for this referral being made?

- ◯ Child/young person consent
- ◯ Care giver consent
- ◯ No

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

- ◯ Referrer
- ◯ Young person
- ◯ Primary carer

Has the client accessed SASS previously?

- ◯ Yes
- ◯ No

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
- ☐ Male
- ☐ Transgender
- ☐ Non-binary
- ☐ Prefer not to say

Preferred pronouns:

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

Age:

_____

Date of Birth:

_____ _____ _____

Day Month Year

Cultural identity:

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

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

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

Current school (if attending):

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

Phone Number

Area Code | Phone Number

Is this a safe number to receive calls, texts and voice messages?

- ◯ Yes
- ◯ No

Email:

Does anyone else have access to this email account that may compromise the client's privacy?

- ◯ Yes
- ◯ No

Preferred form of contact

- ◯ Phone
- ◯ Email

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

Who else resides with the client?

Contact name:

First Name | Last Name

Phone Number

Please enter a valid phone number.

Relationship to client:

If the client has a significant support person, carer, parent or guardian please provide their details below.

Name

First Name Last Name

Relationship to client:

Phone:

Area Code Phone Number

Email:

example@example.com

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

- ◯ Yes
- ◯ No

Will this person be organising the appointments at SASS?

- ◯ Yes
- ◯ No

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

Approximately how long ago did the client make the disclosure?

Sexual abuse history (timeframe since the last assault):

- ☐ 72 hours or less
- ☐ 1 year or less
- ☐ 1-5 years
- ☐ More than 5 years
- ☐ Unspecified
- ☐ Ongoing and current

Relationship of alleged perpetrator to the client:

- ☐ Familial / Family Friend
- ☐ Other

Persistence of sexual abuse:

- ☐ Ongoing & Repeated
- ☐ Once off

Self-harm:

- ◯ Active (please provide details below)
- ◯ Infrequent / not current concern

If self-harm is assessed as active, please provide additional details:

E.g. frequency, severity, hospitalisation

Suicidal thoughts:

- ◯ Active (please provide details below)
- ◯ Infrequent / not current concern

If suicidal thoughts is assessed as active, please provide additional details:

(e.g. frequency, severity, hospitalisation)

Please provide details of the sexual assault or harmful sexual history if possible:

If the client you are referring has experienced sexual harm from another young person, please name the young person who caused the harm (if known)?

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

Did the abuse include any technology-facilitated abuse? If yes, did it involve:

- ☐ Coercive control
- ☐ Image based
- ☐ Online
- ☐ Online and image based
- ☐ Stalking/monitoring
- ☐ Other

Are there current Legal Orders in place:

- ◯ Child Safety Services
- ◯ Family Court
- ◯ Other

Have any of the following taken place:

- ☐ Police Involvement
- ☐ Forensic Medical Examination
- ☐ Other

Has the client experienced or witnessed Family Violence?

- ◯ Yes
- ◯ No
- ◯ Unknown

If yes, is this:

- ◯ Current
- ◯ Historic

Has a notification to the Strong Families Safe Kids Advice and Referral Line been made?

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

Notification date:

Day Month Year

Name of worker:

Reference number:

Are there any safety concerns for the client?

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

What is the client's family support network?

What is the client's social and peer support network?

Current professional supports:

- ◯ No
- ◯ Other

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

E.g. good self-regulation, engages in good self-care, uses hopeful coping strategies, good communication skills, strong interests or hobbies etc

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

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24/7 MY SUPPORT: 1800 697 877