

Referral Form

Detention/Community detention



Foundation
House

The Victorian Foundation
for Survivors of Torture Inc.

Questions about completing this form? Telephone (03) 9389 8900

Please complete this form on screen, print it out and either:

- fax it to (03) 9277 7871
- email to referrals@foundationhouse.org.au
- post it to 4 Gardiner St, Brunswick VIC 3056

Please note:

- You MUST have the consent of the person you are referring before sending this form to Foundation House.
- You can use this form to refer multiple family members – see ‘Referral of family members’ section.
- Please complete as much information on this form as you can.
- A Foundation House worker will contact you within 5 working days after receipt of this form to discuss the referral.

COVID-19 update

Due to the current COVID-19 restrictions we are encouraging non face to face modes of contact. What is the person being referred’s preferred mode of contact at this time?

- Phone call Text message Video conferencing platform (Zoom/Web X/Skype)
 Other (Please specify)

Referrer

DATE REFERRAL MADE (dd/mm/yyyy)	REFERRING AGENCY/ORGANISATION	
WORKER NAME		
STREET ADDRESS		
SUBURB	STATE	POSTCODE
EMAIL		
TELEPHONE	MOBILE	FAX

Consent

Does the person being referred consent to the referral?	<input type="checkbox"/> YES
Does the person being referred consent to being contacted directly by Foundation House?	<input type="checkbox"/> YES <input type="checkbox"/> NO
If the person being referred is under 18 years of age, does their parent/guardian consent to the referral?	<input type="checkbox"/> YES <input type="checkbox"/> NO

Person being referred

FAMILY NAME	GIVEN NAME/S	
DATE OF BIRTH (dd/mm/yyyy) – please estimate if exact date not known	GENDER <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Prefer to self-describe: _____	
STREET ADDRESS		
SUBURB	STATE	POSTCODE
EMAIL		
TELEPHONE	MOBILE	
COUNTRY OF ORIGIN	ETHNICITY	

PREFERRED LANGUAGE	INTERPRETER REQUIRED? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, GENDER PREFERENCE FOR INTERPRETER? <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> No preference
GENDER PREFERENCE FOR FOUNDATION HOUSE WORKER? <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> No preference		IF THE PERSON ATTENDS SCHOOL, SCHOOL NAME

Referral of family members (attach additional pages if necessary)

Please note:

- You MUST have the consent from the family member/s you are referring before sending this form to Foundation House.
- A parent/guardian can consent on behalf of their child/ren.

FAMILY NAME	GIVEN NAME/S
DATE OF BIRTH (dd/mm/yyyy) – please estimate if exact date not known	RELATIONSHIP WITH THE PERSON BEING REFERRED (eg spouse, child, sibling)
DOES THE PERSON CONSENT TO THE REFERRAL? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF THE PERSON ATTENDS SCHOOL, SCHOOL NAME
FAMILY NAME	GIVEN NAME/S
DATE OF BIRTH (dd/mm/yyyy) – please estimate if exact date not known	RELATIONSHIP WITH THE PERSON BEING REFERRED (eg spouse, child, sibling)
DOES THE PERSON CONSENT TO THE REFERRAL? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF THE PERSON ATTENDS SCHOOL, SCHOOL NAME
FAMILY NAME	GIVEN NAME/S
DATE OF BIRTH (dd/mm/yyyy) – please estimate if exact date not known	RELATIONSHIP WITH THE PERSON BEING REFERRED (eg spouse, child, sibling)
DOES THE PERSON CONSENT TO THE REFERRAL? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF THE PERSON ATTENDS SCHOOL, SCHOOL NAME
FAMILY NAME	GIVEN NAME/S
DATE OF BIRTH (dd/mm/yyyy) – please estimate if exact date not known	RELATIONSHIP WITH THE PERSON BEING REFERRED (eg spouse, child, sibling)
DOES THE PERSON CONSENT TO THE REFERRAL? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF THE PERSON ATTENDS SCHOOL, SCHOOL NAME
FAMILY NAME	GIVEN NAME/S
DATE OF BIRTH (dd/mm/yyyy) – please estimate if exact date not known	RELATIONSHIP WITH THE PERSON BEING REFERRED (eg spouse, child, sibling)
DOES THE PERSON CONSENT TO THE REFERRAL? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF THE PERSON ATTENDS SCHOOL, SCHOOL NAME
FAMILY NAME	GIVEN NAME/S
DATE OF BIRTH (dd/mm/yyyy) – please estimate if exact date not known	RELATIONSHIP WITH THE PERSON BEING REFERRED (eg spouse, child, sibling)
DOES THE PERSON CONSENT TO THE REFERRAL? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF THE PERSON ATTENDS SCHOOL, SCHOOL NAME
FAMILY NAME	GIVEN NAME/S
DATE OF BIRTH (dd/mm/yyyy) – please estimate if exact date not known	RELATIONSHIP WITH THE PERSON BEING REFERRED (eg spouse, child, sibling)
DOES THE PERSON CONSENT TO THE REFERRAL? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF THE PERSON ATTENDS SCHOOL, SCHOOL NAME

Please note: all following questions are about the main person being referred (not family members)

Migration processing status

DATE OF ARRIVAL IN AUSTRALIA (THIS INCLUDES CHRISTMAS ISLAND) (dd/mm/yyyy)	STATUS ON ARRIVAL	
	<input type="checkbox"/> Authorised	<input type="checkbox"/> Unauthorised
HAS THE PERSON BEEN TRANSFERRED TO AUSTRALIA FROM EITHER THE NAURU OR MANUS OFFSHORE PROCESSING CENTRE?	IF YES, DATE OF TRANSFER	
<input type="checkbox"/> YES <input type="checkbox"/> NO		
PV APPLICATION STAGE	<input type="checkbox"/> Pre-interview/Pre-primary decision <input type="checkbox"/> IAA/AAT review <input type="checkbox"/> Post-review decision/Judicial review	
LEGAL REPRESENTATIVE NAME	TELEPHONE	
NOTES (attach additional pages if necessary)		

Detention history in Australia and/or Manus/Nauru (if known)

PLACE OF DETENTION	START DATE OF DETENTION	END DATE OF DETENTION
PLACE OF DETENTION	START DATE OF DETENTION	END DATE OF DETENTION
PLACE OF DETENTION	START DATE OF DETENTION	END DATE OF DETENTION
PLACE OF DETENTION	START DATE OF DETENTION	END DATE OF DETENTION
DATE RELEASED INTO COMMUNITY DETENTION (dd/mm/yyyy)		

Health

IHMS PROVIDER NAME		
STREET ADDRESS		
SUBURB	STATE	POSTCODE
EMAIL		
TELEPHONE	MOBILE	FAX
PHYSICAL HEALTH COMMENTS (attach additional pages if necessary)		
PROFESSIONALS INVOLVED		
MENTAL HEALTH COMMENTS (attach additional pages if necessary)		
PROFESSIONALS INVOLVED		
CURRENT MEDICATIONS (attach additional pages if necessary)		

Referral indicators for torture and other traumatic events

HAS THE PERSON BEING REFERRED (tick/click on those which apply):

- disclosed experience of torture or other traumatic events with or without prompting?
- disclosed injury/ies or pain which is/are the result of torture, sexual assault or other form of violence?

TORTURE AND TRAUMA EXPERIENCE (attach additional pages if necessary) A possible question to ask about torture and trauma: "Some people have had bad things happen to themselves and their families. Has anything happened to you or your family that is affecting the way you are feeling now?"

OBSERVATIONS: Tick/click on those which apply – no questions are required, you may observe these or the person may disclose them spontaneously.

ADULTS (only)

- Crying a lot
- Intense/persistent emotional distress
- Persistent lack of expression of positive emotions
- Aggressive behaviour or persistent anger
- Fears of going out or other fears
- Severe social withdrawal or appears uncommunicative
- Repeated expressions of hopelessness
- On alert for things going wrong
- Overreacting to noises etc in environment
- Peculiar appearance, behaviour or speech
- Alcohol or substance abuse
- Poor self care, household care
- Persistent physical ailments with no medical cause
- Not responding to needs of children, emotional distance
- Persistent and severe sleep difficulties
- Signs of family conflict
- Appears disoriented, incoherent or confused
- Expresses bizarre or illogical beliefs
- Expresses threat to harm self or others

CHILDREN and ADOLESCENTS

- Crying a lot
- Intense/persistent emotional distress
- Persistent lack of expression of positive emotions
- Aggressive behaviour or persistent anger
- Fears of going out or other fears
- Severe social withdrawal or appears uncommunicative
- Overreacting to noises in environment
- Peculiar appearance, behaviour or speech
- Risk taking behaviour
- Alcohol or substance abuse
- Expresses threat to harm self or others
- Sleep problems (too much or too little)
- Nightmares
- Re-enactment of a traumatic event in play
- Lots of worries
- Out of control behaviour
- Bed-wetting
- Frequent tantrums
- Not wanting to go to school or infrequent attendance
- Persistent headaches or other aches
- Failure to thrive
- Very clingy behaviour

OTHER COMMENTS ABOUT REASON FOR REFERRAL (attach additional pages if necessary)

SUPPORTS

WHAT SUPPORTS DOES THE PERSON HAVE IN AUSTRALIA?

OTHER AGENCY INVOLVEMENT NOT PREVIOUSLY MENTIONED

AGENCY	CONTACT PERSON	TELEPHONE
AGENCY	CONTACT PERSON	TELEPHONE
AGENCY	CONTACT PERSON	TELEPHONE
AGENCY	CONTACT PERSON	TELEPHONE
AGENCY	CONTACT PERSON	TELEPHONE
AGENCY	CONTACT PERSON	TELEPHONE

COMMENTS: