



Children's Health Queensland
Hospital and Health Service
School Based Youth Health Nurse
Service (SBYHN)

(AFFIX PATIENT IDENTIFICATION LABEL HERE)

Young Person Referral

School name:

Date of referral:

Referring agent's name:

Student is aware of the referral and consents to an appointment? Yes No

Note: Students need to provide verbal consent for a SBYHN service

Student name:

Year level:

Date of birth:

Gender:

Home address:

Student contact phone:

Next of Kin:

Relationship to student:

Phone:

Indigenous status:

- Aboriginal but not Torres Strait Islander Torres Strait Islander but not Aboriginal Not stated / unknown
 Both Aboriginal and Torres Strait Islander Not Aboriginal or Torres Strait Islander

Australian South Sea Islander status: Yes No Not stated / unknown

Has the student given consent for the Nurse to email an appointment? Yes No

If yes, student's email address:

Is an interpreter required? Yes No ► If yes, which language?

Identified or suspected concerns? (tick all that apply)

- Mental health General health and wellbeing Family issues
 Sexual health Alcohol and other drugs Relationship issues
 Nutrition and/or exercise Grief and loss Other:

Additional information:

Please note: The School Based Youth Health Service does not provide an immediate response.

If this referral requires an immediate response due to a high risk to self or others, please follow your organisation's emergency response procedures or call **000**.

If a disclosure has been made to you in relation to a child protection issue contact the Guidance Officer or Deputy Principal immediately. It is **MANDATORY** to **IMMEDIATELY** report if you become aware of, or reasonably suspect, abuse.

- Referral to be emailed to the School Based Youth Nurse for the school (ie. nurse.greensfields@health.qld.gov.au)

PLEASE NOTE: ONE REFERRAL PER EMAIL

DO NOT WRITE IN THIS BINDING MARGIN



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