



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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