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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