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School Referral Guide

Child & Youth Mental Health Service Access Team - New Referral

**Email:**  CYMHSAccessTeam@health.qld.gov.au

**Fax:** 07 5635 6450

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| Referrer Details | | | | | | | | |
| **Name:** |  | | | | | | **Date of Referral:** | |
| **School:** |  | | | | | | | |
| **Position:** |  | | | | | | | |
| **Phone Contact:** |  | | | | | | | |
| **Email Contact:** |  | | | | | | | |
| **Do you want to be contacted regarding this referral?** | | | | | | | Yes  No | |
| Please Note: CYMHS will only contact the referrer to discuss the referral if additional information is required. Feedback will be provided where possible and only if consent to share information has been obtained. | | | | | | | | |
| **Student Details** | | | | | | | | |
| **Given name/s:** |  | | | | **Family name:** | | | |
| **Preferred name/s:** |  | | | | | | | |
| **Gender:** | Male | | Female | Non-Binary | | Other - Please specify: | | |
| **Cultural identity(s):** |  | | | | | | | |
| **Date of birth:** |  | | | | | | | |
| **Phone contact:** |  | | | | | | | |
| **Email:** |  | | | | | | | |
| **Address:** |  | | | | | | | |
| **Is the young person aware of this referral?** | | | | Yes  No | | | | |
| **Parent / Guardian Details** | | | | | | | | |
| **Name/s:** |  | | | | | | **Contact:** | |
|  | | | | | | **Contact:** | |
| **Address:** |  | | | | | | | |
| **Email:** |  | | | | | | | |
| **Is the parent / guardian consenting to this referral?** | | | | | | | Yes  No | |
| **Is the young person under the care of the Department of Communities?** | | | | | | | Yes  No  Unsure | |
| **Reason for referral / presenting problems**  (describe the mental health concerns you have identified and what you are requesting from CYMHS) | | | | | | | | |
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| **Relevant History**  (include any known history of the identified problem/s, any developmental issues and/or details of any assessments conducted by the school) | | | | | | | | |
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| **Past / Current Treatments** (if known) | | | | | | | | |
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| **Current Functioning**  (Home, living arrangements, family structure, education, employment, sexuality, gender, relationships, activities) | | | | | | | | |
|  | | | | | | | | |
| **Risk Concerns**  (include risk of suicide, self-harm, violence, risk taking behaviour, substance misuse, family history of mental illness, vulnerability to abuse or neglect, limited social supports, legal issues) | | | | | | | | |
|  | | | | | | | | |
| **Additional Contact/s** | | | | | | | | |
| **General Practitioner:** | |  | | | | | | **Contact:** |
| **Private Psychologist:** | |  | | | | | | **Contact:** |
| **Private Psychiatrist:** | |  | | | | | | **Contact:** |
| **Paediatrician:** | |  | | | | | | **Contact:** |
| **Non-Government Organisation:** | |  | | | | | | **Contact:** |
| **Are there any other services involved with this young person, if so please give details:** | | | | | | | | |
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| **Please note this document was developed to be used as a guide in supporting school staff when providing additional information to support to referral to CYMHS. All referral to CYMHS must be phoned through in the first instance to ensure the referral has been received. The personal information included on this form has been collected and distributed with the informed consent of the young person/parent/carer. If the young person is at immediate risk of injury to themselves or others, please call CYMHS Access Team on 1300 MH CALL (1300 64 22 55) or emergency services on 000.** | | | | | | | | |