RESET FORM

West Moreton
Adapted from CHQ

Queensland Government

School Based Youth Health Nurse (SBYHN) Young Person Referral

Facility: ……

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth: Sex: ☐ M ☐ F ☐ I

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 to participate in a SBYHN service).

Student first name: **Last name:**

Known as/Alias:

Date of birth: **Gender:** **Year level:**

Home address:

Student contact phone:

☐ **Aborignal** ☐ **Torres Strait Islander** ☐ **Both** ☐ **Neither** ☐ **Unknown**

NESB: ☐ Yes ☐ No **SEP:** ☐ Yes ☐ No

Is an interpreter required? ☐ Yes ☐ No ▶ If **yes**, which language:

Parent/NOK/Guardian name: **Phone:**

Relationship to student:

Identified or suspected concerns? (tick all that apply and provide brief description below)

- ☐ Sexual health
- ☐ General health and wellbeing
- ☐ Alcohol, tobacco and vaping
- ☐ Nutrition
- ☐ Puberty and hygiene
- ☐ Other: (Please specify)

Brief description of referring issue:

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

If this referral requires and immediate response due to a high risk to self or others, please follow your organisation's emergency response procedures and 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 encrypted and emailed to the School Based Youth Health Nurse email WM_SBYHN@health.qld.gov.au

SCHOOL BASED YOUTH HEALTH NURSE YOUNG PERSON REFERRAL

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