Queensland Government

Central Queensland Hospital and Health Service

Child & Youth Mental Health Service Referral Form

Facility / Unit: ....

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Phone:

Date of birth: Sex: ☐ M ☐ F ☐ I

REFERRER INFORMATION **Date of referral:** / /

Referral from (Name): ………………………………………… **Designation:** …………………………………………………

Service/Facility: …………………………………………….. **Phone Number:** ………………………………………..

CLIENT INFORMATION

Name: …………….. **Date of Birth:** / /

Street Address: ……………………………………………………………… **Town/Suburb:** …………………………………..

Phone Number: ……………………………………………….. **Mobile:** ……………………………………………………...

Country of Birth: …………………………………………….. **Indigenous Status:** ……………………………………….

Does the young person give permission for the referral? YES ☐ NO ☐

NEXT OF KIN INFORMATION

Name: ……………... **Relationship to young person:** …………………………..

Street Address: ……………………………………………………………… **Town/Suburb:** …………………………………..

Phone Number: ……………………………………………….. **Mobile:** ……………………………………………………...

Does this person have legal custody? YES ☐ NO ☐

Does next of kin give permission for the referral? YES ☐ NO ☐

REFERRAL INFORMATION

Reason for Referral (e.g. symptoms of severe and complex mental illness of concern, e.g. anxiety, low mood, self harm)

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Are there current risks present? (include details, e.g. current thoughts or plans of suicide/self harm etc)

Self harm behaviour:……………………………………………………………………………………………………

………

Suicide:………

………

Aggression: ………

………

Please note: If the referral is URGENT or if you are unsure if CYMHS is the appropriate service to help, please phone CYMHS and discuss your concerns:-
Business Hours:- Rockhampton (4920 5700); Emerald (4983 9750); Gladstone (4976 3244); Biloela (4992 7000); **After Hours:-** Acute Care Team (4920 6111)

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CHILD & YOUTH MENTAL HEALTH SERVICE REFERRAL FORM

Queensland Government

Central Queensland Hospital and Health Service

Child & Youth Mental Health Service
Referral Form

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Date of birth: Sex: ☐ M ☐ F ☐ I

REFERRAL INFORMATION cont.

How are these problems impacting on the young person? (e.g. declining school performance, disruption to relationship with family/peers etc.):

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Relevant History (e.g. medical, social, home environment, previous assessment results/diagnosis etc.)

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Is the young person currently involved with other services? (e.g. GP, Child Safety, psychologist, treating doctor, non government agency):

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Any additional information?

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Referrals to be faxed to relevant CYMHS:-
Rockhampton (4920 5719); Emerald (4983 9744); Gladstone (4976 3377); Biloela (4992 7064)
Please note: All referrals to CYMHS are reviewed through the normal intake processes to determine eligibility for CYMHS intervention, i.e. severe and complex mental illness. CYMHS is a community based outpatient service and will prioritise intakes according to risk.

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