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Queensland Government

Darling Downs Health

Referral to Child and Youth Mental Health Service (CYMHS)

(for use by schools and other community organisations)

Facility

(Affix identification label here)

URN: Phone:

Family name:

Given name(s):

Address:

Date of birth: Sex ☐ M ☐ F ☐ Indeterminate

Medicare: ID: Exp:

Date of referral:

Obtain consent

Is the young person aware of this referral? ☐ Yes ☐ No

If 'No' record reason/s for not consulting with young person:

If under 16 years of age, does the parent/guardian consent to this referral? ☐ Yes ☐ No

If 'No' record the reason/s for not obtaining consent from parent/guardian:

If 16 years or over, does the young person consent to this referral? ☐ Yes ☐ No

If 'No' record the reason/s for not obtaining consent from parent/guardian:

Please attach signed consent form if applicable.

Do you want to be contacted regarding the outcome of this referral? ☐ Yes ☐ No

If 'Yes' what is your best contact:

Please note: CYMHS will contact the referrer to confirm receipt of the referral and whether the young person has been accepted for assessment. Further information will only be shared if consent to do so has been obtained.

Referrer details:

Referrer's name:

Referrer's role and organisation:

Referrer's phone contact:

Referrer's email contact:

Child details:

The child or young person being referred must be consulted. Provide alternative names this young person may be known by.

Name of child/young person:

Address:

Date of birth:

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Indigenous status:

☐ Aboriginal but not Torres Strait Islander
☐ Torres Strait Islander but not Aboriginal
☐ Both Aboriginal and Torres Strait Islander
☐ Not Aboriginal or Torres Strait Islander
☐ Not stated / unknown

We have Aboriginal and Torres Strait Islander Health Workers who can provide cultural support to you and your family. Would you like to know more about their role?

☐ Yes ☐ No

Is there an additional adult support person you would like us to know about? If so, specify:

Parent/Guardian details:

Parent/guardian consent is required for the child and youth under 16 years of age.

Name of parent/guardian:

Address:

Phone: **Mobile:** **Email:**

Is the young person under the care of the Department of Communities? ☐ Yes ☐ No

☐ Out of home care ☐ Kinship care

Name of Child Safety Officer:

Child Safety contact details:

Reasons for referral

(Describe the mental health problem/s you have identified and what you are requesting from CYMHS – e.g. depression, anxiety disorders, eating disorders or early psychosis)

Relevant history

(Include any known history of the identified problem/s; any known developmental issues and details of any assessment conducted by the school – e.g. psychological/psychometric, speech and language or occupational therapy and school reports)

DO NOT WRITE IN THIS BINDING MARGIN

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Current medications *(if known)*

Your risk concerns *(include risk of suicide; self harm or violence towards other; risk taking behaviour - e.g. substance misuse; family history of mental illness; vulnerability to abuse or neglect; limited social supports)*

Note: If the young person is at immediate risk of injury to themselves or others, call Emergency Services on 000 (for QAS), or present to the Emergency Department of your nearest hospital (after consulting with the parent/s.)

If there are any other services involved with the young person, please give details:

☐ Paediatrician: Contact:

☐ GP: Contact:

☐ Private Psychiatrist: Contact:

☐ Private Psychologist: Contact:

☐ School support staff: Contact:

☐ NGOs *(e.g. Mercy Family Services, Lifeline)*:

☐ Youth Justice: Contact:

☐ NDIS - self managed ☐ *OR* Support Coordinator Contact:

☐ Other:

Please detail any support that has been provided to the young person prior to this referral:

Attach copies of relevant documents to support your referral, e.g. WISC assessment, school management plans, SSMH1 consent form, etc.

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EMAIL or FAX this form to the appropriate service below, and/or telephone if you wish to discuss this referral:

Note: If the young person is at immediate risk of injury to themselves or others, call Emergency Services on 000 (for QAS), or call your local intake on the numbers provided.

	Fax Number	Phone *(business hours)*	Phone ACT *(outside business hours)*
A. South Burnett (Kingaroy)	4162 0488	4162 0487	4616 5210
	Email: SBMHAODS@health.qld.gov.au		
B. Southern Downs (Warwick)	4660 3727	4660 3901	4616 5210
	Email: SD_CYMHS@health.qld.gov.au		
C. Western Downs (Dalby)	4669 0794	4669 0501	4616 5210
	Email: WDMH@health.qld.gov.au		
D. Toowoomba	4616 5399	4616 6843	4616 5210
	Email: Toowoomba_CYMHS@health.qld.gov.au		

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