**REFERRAL FORM**

**This service is not an emergency service. Please ring the team directly if you require a prompt discussion. If a woman needs to be seen as an emergency, please contact GP.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Client Details** | | | | | |
| **Name:** |  | | | | |
| **Date of Birth:** | < 16 yrs, please refer to Child and Adolescent Mental Health Service, CAMHS  < 18 yrs, referral can be made as long as open to a secondary mental health service | | | | |
| **NHS number:** |  | | | | |
| **Address:** |  | | | | |
| **E-mail Address:**  (for setting up video consultations) |  | | | | |
| **Contact numbers:** |  | | | | |
| **GP (name and address):** |  | | | | |
| **Next of Kin:** | Name:  Address:  Contact Number: | | | | |
| **Ethnic Origin:** |  | | | | |
| **Interpreter required/**  **Additional needs:** | Yes  Language:  No | | | | |
| **Relationship Status:** |  | | | | |
| **Employment Status:** |  | | | | |
| **Accommodation Type:** |  | | | | |
| **Partner**  **Full name & DOB:** |  | | | | |
| **Father of Baby**  **Full name & DOB:**  (if different) |  | | | | |
| **Baby’s full name & DOB** (if born)**:** |  | | | | |
| **Dependant’s**  **Names & DOB:** | Child 1 Name: | | | DOB: | |
| Child 2 Name: | | | DOB: | |
| Child 3 Name: | | | DOB: | |
| **Obstetric Details** | | | | | |
| **EDD** |  | | **Gestation in weeks** | |  |
| **Preference for delivery**  (please circle) | **Hereford Home Other** (Please Specify) | | | | |
| **Professional Details: Address & Contact Numbers** | | | | | |
| **Midwife** | |  | | | |
| **Consultant Obstetrician** | |  | | | |
| **Health Visitor** | |  | | | |
| **Consultant Psychiatrist** | |  | | | |
| **Care Coordinator** | |  | | | |
| **Social Care** | | **Worker/Profession:**    **Level of involvement: Early Help Assessment**  **Child in Need**  **Child Protection Plan** | | | |

|  |  |
| --- | --- |
| **Pre-Conception Advice**  We offer one off appointments for women with a history of severe mental illness who are planning a pregnancy. | |
|  | Please indicate if preconception advice only is required |

|  |  |
| --- | --- |
| **Current Medication** | |
| Please provide details and dosage |  |

|  |  |  |
| --- | --- | --- |
| **Emergency Symptoms (select all that apply)** | | |
| Suspected puerperal psychosis | | Strong suicidal thoughts/plans |
| Hostile thoughts about baby with intent to harm the baby | | |
| **If any of the above symptoms are present or if there are any other significant risk factors, please contact Perinatal Mental Health Team for discussion within working hours.**  **Out of working hours, please use GP/Emergency Services as appropriate.** | | |
| **Perinatal Symptoms and Related Factors (Select all that apply & provide further detail below)** | | |
| The Perinatal Team will consider patients with difficulties that develop perinatally (i.e. in pregnancy or up to 12 months postnatally), or when pre-existing conditions are made worse during the perinatal period. | | |
| Thoughts or acts of harm to self or others  History of psychosis (postnatal or not)  Diagnosis of bi-polar disorder | Obsessive compulsive symptoms/intrusive thoughts  Fears she may harm the baby  Moderate to severe anxiety based disorder (including extreme fear of childbirth) | |
| Family history of bi-polar disorder | Post-traumatic symptoms relating to childbirth | |
| Severe bonding issues / mother-infant  attachment issues | Moderate or severe postnatal depression (no hospitalisation) | |
| Moderate to severe depressive illness | Postnatal depression requiring hospitalisation | |
| **Additional Factors:** |  | |
| Drug and alcohol misuse | Partner has a serious mental illness | |
| History of depressive episodes | Feels socially isolated | |
| Self-harm attempts in the past 2 years | Eating disorder | |
| Previous social care/child protection  involvement with any other children | Domestic abuse (state below past or current) | |
| Family history of serious psychiatric illness i.e. mania, depression or schizophrenia | Other psychiatric illness – diagnosis (specify) | |
|  | Difficulty adjusting to complex medical factors  in pregnancy | |
| Are these problems: Current Previous Both  | | |

|  |  |
| --- | --- |
| **Presenting problem at referral and any additional information** | |
| Please provide detailed clinical information of current presentation and impact on functioning. | |
| **Current Mental Health Input** | |
|  | |
|  |  |
| **Consent** | |
| I have made the person aware and they are happy for referral? Yes  No  I have made the person aware that their information will be shared between Multiagency Teams in order to signpost them to the appropriate service? Yes  No | |
| I have been given consent by the person to leave telephone messages as required using the telephone numbers provided? Yes  No | |
| I have been given consent to use the e-mail address provided to set up virtual online appointments?  Yes  No | |
| I have been given consent for this referral to be redirected to Healthy Minds if appropriate?  Yes  No | |
| **Signature of Referrer: Date:** | |
| **Name (block capitals):** | |

|  |  |
| --- | --- |
| **Referrer Details** | |
| Job Title | Address |
| Name |
| Telephone |

**Perinatal Community Mental Health Team**

**A member of the team is available to provide consultation and advice Monday to Friday, 9am to 5pm. Please telephone 01432 220445 and ask for Perinatal Services.**

**Send form to:** Whcnhs.herefordperinatalmentalhealthservice@nhs.net