**Perinatal Mental Health Team Referrals**

**Please read the following before proceeding with your referral:**

* This service operates Monday to Friday 9am – 5pm. We ask that you ring to discuss you referral prior to sending the information (with team duty cover, via admin’ 01482 336837). If you are unable to ring first and you feel this referral is urgent please be aware there will be no-one available to respond outside of office hours and you should contact your Single Point of Access or Hospital Liaison Team.
* Please complete all fields of the form as it may not be processed if there is missing information. Only referrals received on this form will be processed and other documentation should only be sent as supplementary to this.
* Once complete, please email to HNF-TR.PerinatalMentalHealthTeam@nhs.net

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| **Date and time of referral** | **Referrer details**  Name:  Role:  Telephone Number:  Email:  Address: |
| **Is the person aware of and consenting to this referral?** Y/ N  **Does the patient agree for their referral to be discussed with other relevant professionals to ensure they receive the most appropriate service** Y/N | **Are there preferred days/ times/ means to contact the person?** |
| **GP details**  Name:  Practice name/ address:  Telephone: | **Names and details of other professionals involved** |
| **Name of person being referred (including title and preferred name)** | **NHS Number**  **Date of birth/ age** |
| **Ethnicity**  **Spoken language/ sign language**  **Interpreter/ sign language user needed?** | **Self-identified gender/ chosen pronouns**  **Sexual orientation**  **Marital status** |
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| **Address of person being referred and, if not at home, current location** | **Home Number**  **Mobile number**  **Is it ok to leave a message?** |
| **Employment status**  **Armed forces** Y/ N  Current  Ex | **Religion**  **Accomodation status** |
| **DOB or Estimated Delivery Date of baby**  **Who has/ will have parental responsibility?**  **Are Children’s Social Care Involved?** | **Names and DOB for any other children, who has parental responsibility?**  **Any children not in care of person?**  **Current or previous Children’s Social care involvement** |
| **Next of kin/ significant other**  Name:  Relationship:  Address:  Contact number | **Is person referred happy for us to contact NOK/ significant other?** |

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| **Reason for referral**  Current presentation/ situation, signs of poor mental health or distress. Any emotional/ mental health treatment being provided? Are there physical health,social/ relationship factors or substance misuse issues contributing to the situation?  Concerns relating to risk, nature of risk, who is risk to and from?  Does the person being referred/ significant others have a different view of the situation/ risk?  **Does the referrer have any concerns about the attachment/ bonding between the person being referred and their (unborn) baby? Any concerns around how they are coping with being a parent?**  **Has a safeguarding referral been considered?** |
| **Historical mental health involvement/treatment/interventions and risk** |
| **Current or historical obstetric complications/ risks** |
| **Any other physical health complications/ risks, any allergies?** |
| **Prescribed medication (please provide all current medications and any any previous medications for mood or psychosis)** |
| **Any other information you feel is important to the referral** |
| **Please indicate which treatment pathways you feel would be appropriate for the person being referred (preconception counselling, specialist assessment, urgent assessment, psychological interventions- including which ones or admission to a Mother and Baby Unit)**  **Does the person being referred/ their significant others have differing ideas about what treatment would be helpful?** |
| **For Perinatal Team Clinicians-**  if referral rejected without triage please ensure rationale is provided to the referrer and documented in notes |

**\*Expand sections as required\***