**REFERRAL FOR DERBYSHIRE PERINATAL COMMUNITY MENTAL HEALTH SERVICE**

**INFORMATION FOR REFERRERS**

The Perinatal Community Mental Health Service offers specialised treatment to women experiencing moderate to severe and complex mental health difficulties during pregnancy and the postnatal period. The team offers assessment and treatment of their mental illness whilst ensuring the developing relationship with the baby or processing the loss of a pregnancy / baby.

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| **Please select the reason(s) for referral**  |
|  [ ]  Pre-conception counselling for those with existing serious mental illness  [ ]  Women who have developed significant mental health difficulties after the first trimester in pregnancy or following delivery that cannot be managed in primary care  [ ]  Diagnosis of serious mental illness such as bipolar affective disorder, schizophrenia,  severe depression, or anxiety disorder  [ ]  Previously under the care of perinatal mental health services   [ ]  Previous admission to a psychiatric unit    [ ]  First degree relative with bipolar disorder or serious postnatal illness   [ ]  Significant disorders of bonding and attachment [ ]  PTSD symptoms following loss or birth trauma  [ ]  Loss of pregnancy due to miscarriage or medical termination [ ]  Stillbirth  [ ]  Loss of baby within 28 days following birth or following admission to neonatal unit [ ]  Primary or secondary Tokophobia |

If you are unsure as to whether your referral meets the criteria please contact our advice line Monday, Tuesday, Thursday, Friday 9.30 – 12pm on 0300 123 7596 to discuss.

**Please fill out all the details and once completed email to:**

**dhcft.perinatalcmht@nhs.net**

**PERINATAL COMMUNITY MENTAL HEALTH SERVICE REFERRAL FORM**

***(If all details are not completed it will delay the referral process)***

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| **DATE OF REFERRAL:** ……………………… **PATIENT CONSENT OBTAINED:** Yes[ ] No[ ]  |
| **Routine** [ ] **Urgent** [ ]  **If urgent, please give clinical rationale below**: |

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| PATIENT DETAILS  |
| Title: Miss [ ]  Mrs [ ]  Ms. [ ]  Mx. [ ]  Another title or none is used (please specify) [ ]   |
| First name: Preferred name (if applicable):  |
| Surname:  |
| NHS number: |
| Address & Postcode: |
| Date of Birth: |
| Telephone: |
| Ethnicity: |
| Preferred language: |
| Interpreter needed: Yes [ ]  No [ ]  |
| If pregnantEDD:Place of booking for delivery:Date of loss if applicable: |
| **REFERRER DETAILS** | **GP’S DETAILS** |
| **Name**:**Job Title**: | **Name**: |
| **Address and Postcode**: | **Address and Postcode**: |
| **Phone number**:**Email**: | **Phone number**: |
| **CHILDREN’S DETAILS** |
| **Name:** | **Date of birth:** | **Gender:**  | **Who does the child reside with:** | **Who has parental responsibility:** |
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| **Any past or current safeguarding concerns?** Yes [ ]  No [ ] **Has a referral to Children’s Services been made?** Yes [ ]  No [ ] *(If yes, please give details of the Team referred to and the date referral was made)***Is there a Child Protection Plan/Child in Need plan in place?** Yes [ ]  No [ ] If there is a Child Protection Plan, Working Agreement or Court Directive please give details including what category the child(ren) is/are registered under and attach a copy of the document if possible. |
| **CURRENT CONCERNS / REASON FOR REFERRAL** **(To include relationship with infant or expected baby/level of functioning with regards to infant care or degree of distress and level of functioning following loss / trauma)** |
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| **CURRENT AND PAST PSYCHIATRIC HISTORY** **(Including risk to self/others)** |
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| **OBSTETRIC HISTORY** **(Please include information on live births as well as previous loss: miscarriage/medical termination, stillbirth, neonatal loss, birth trauma, Tokophobia, and fertility treatment)** |
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| **MEDICAL HISTORY** **(Please include past and current history)** |
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| **CURRENT MEDICATION** **(Please list ALL medication, including those for physical health and date commenced)** |
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