Chesterfield Royal Hospital
NHS Foundation Trust

Calow
Chesterfield
S40 5BL
Tel:- 01246 277271

Women and Children's Division
& Maternity Services

Perinatal Mental Health Referral

Date referred _____

Patient Name _____ Date of Birth _____

Address _____ NHS No _____

_____ Postcode _____

Home Tel _____ Mobile _____ Ethnicity _____

GP Name, Address (full details) Tel No _____

_____

_____

_____

Health Visitor _____ Tel No _____
& base _____

Named Midwife _____ Tel No _____
& base _____

Consultant Care & Consultant Obstetrician _____ Tel No _____

EDD _____ No of weeks at first booking with midwife _____

Gravity _____ Parity _____

Details of previous pregnancies, births and outcomes

Date/Year	Antenatal	Birth	Postnatal	Baby + BW	Comments

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Mental Health History

Please give details of diagnosis; dates, location and who treated them **

Please give details of any psychiatric admissions – when, where & duration

Please give details of any past or current medication

Family History of Serious Mental Health

Please give details of who, diagnosis and treatment received **

Current Presenting Problems/Reason for Referral

Please give as much detail as possible highlighting any concerns **

Any Other Relevant Information

Safeguarding/Child Protection Issues	YES	NO
Interpreting Services required (state language)	YES	NO
Mother aware and consent obtained for referral	YES	NO

Please Sign _____ and print name _____

Contact Tel No:- _____ Date _____

Send to: - Scarsdale, Newbold Road, Chesterfield, S41 7NW Telephone: 01246216523

Or email to:- dmh-tr.perinatalnorth@nhs.net

** Please add continuation sheets if you wish to submit more information.

Copies to:- GP, Health Visitor, Hospital Maternity Records