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| **Perinatal Mental Health**  **Referral Form** |  |

**Once complete ALL referrals should be emailed to** [**awp.perinatalmentalhealthservice@nhs.net**](mailto:awp.perinatalmentalhealthservice@nhs.net).

Fields marked with a **\*** are mandatory

**Referrals will not be acceped if all mandatory fields are not completed. Self referrals will not be accepted.**

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| GAD7 Outcome if known | PHQ9 Outcome if known | Whooley Outcome if known |
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# Section 1 – Birthing Hospital (Antenatal Referrals Only \*)

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| **Birthing Details**\*  Birthing Hospital/Place: | Southmead Hospital  St Michael’s Hospital  Other (please specify here) | How many weeks pregnant at referral? \* | /40 |
| Estimated Due Date (if known): |  |

# Section 2 – Referrer Details \*

|  |  |  |  |
| --- | --- | --- | --- |
| Your Name: \* |  | Your Email Address: \* |  |
| Your Job Title: \* |  | Your Telephone: \* |  |
| Your Organisation /Base: \* |  | Date of Referral: \* |  |

# Section 3 – Patient Details \*

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| **Has the patient consented to the referral?** \* Referral cannot be accepted without patient consent | Yes  No | This includes consent to be screen at multi-agency perinatal meeting and contacted / message left on telephone. See end of document |
| **If the patient has not given consent because they lack or may lack capacity, please detail:** |  | |

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| Full Name: \* |  | Preferred Name  & Pronouns : |  |
| Date of Birth: \* |  | Address: \* |  |
| Telephone No: \* |  | NHS No: \* |  |
| Gender: \* |  | Sexual Orientation: \* |  |
| Ethnicity: \* |  | Nationality: \* |  |
| Language: \* |  | Is an Interpreter required? \* | Yes  No |
| Religion: \* |  | Any other communication needs? |  |
| Carer Status: \* |  | Ex-Armed Forces: \* | Yes  No |
| Patient’s Next of Kin\*  Name & Telephone: |  | | |
| Children in Household\*  Children’s Name/s & DOB: |  | | |

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| **GP Practice**:\*  Name & Address: |  | **Name of GP**:\* |  |
| Midwifery Team: \* |  | Name of Midwife: |  |
| Health Visitor Team: |  | Name of Health Visitor: |  |
| Social Worker Team: |  | Name of Social Worker: |  |

# Section 4 – Reason For Referral \*

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| **Please include symptoms, current mental health, concerns with mother infant bond / attachment, previous maternal or birth related trauma including obstetric complications affecting mental health** \*  **If the person being referred has symptoms of suspected postpartum psychosis, this is a psychiatric emergency and requires referral to both Specialist Perinatal Team and Crisis or Intensive Support Team for an assessment within 4 hours! Please call to discuss if not sure.** |
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| **Current Risks & Concerns. Please tick the relevant descriptions below:** \* | | | | |
| Risk to self (self-harm, suicide, neglect etc) | |  | Risk to others (safeguarding children/adults) |  |
| Risk of Relapse (based on previous perinatal MH history) | |  | Risk from others (include any people in the home) |  |
| If Yes (ticked) to any please explain risk: |  | | | |

# Section 5 – Personal & Family History \*

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| **Past psychiatric history (including diagnosis, interventions tried, previous maternal / birth trauma or loss, mental health hospital admissions, medication-dose/length and response?**  **Please state any known family history of severe mental illness, in particular with the patient’s mother/sister/aunt which occurred soon after birthing?** \* |
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| **Current medication, counselling or therapy** \* |
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| **Please ask the patient: Do they have any worries or concerns about their unborn / children, including their current relationship with their unborn / children?** \* | Yes  No |
| **If yes, please state their concerns below and what action has been or is being taken, including contact with Safeguarding.** | |
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# University Hospitals Bristol NHS Foundation Trust, the major teaching ...Section 6 – Service Required If Known\*

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **Perinatal Assessment**  *Specialist Community Perinatal Mental Health* | | **MaLT Assessment**  *Midwifery / Trauma**Therapies* | | **Pre-Pregnancy Planning**  *Specialist Community Perinatal Mental Health* | | **Psychiatric Medication Advice & Guidance**  *Specialist Community Perinatal Mental Health* | |
| **Tick Here** |  | **Tick Here** |  | **Tick Here** |  | **Tick Here** |  |
| **REFERRER: Consent Info**  **Please inform your patient that by agreeing to the completion of this form, they are consenting to the referral being screened at an AWP, NBT, UHBW multi-agency referral meeting attended by perinatal commissioned services, a copy being sent to their GP, Midwife and/or relevant Health Visiting team, and the appropriate perinatal maternal mental health pathway being identified. All patients will receive a letter with the outcome of the referral.** | | | | | | | |
| [Image result for exclamation mark red](https://www.google.com/url?sa=i&rct=j&q=&esrc=s&source=images&cd=&ved=2ahUKEwi7rM_u-fDjAhVz6uAKHfTUDpgQjRx6BAgBEAQ&url=https%3A%2F%2Fen.m.wikipedia.org%2Fwiki%2FFile%3AExclamation_mark_red.png&psig=AOvVaw2J5dKfSWKuYTdvlS_9GSGC&ust=1565273912373343)  **Sodium Valproate, Semi-sodium Valproate and Pregabalin is contraindicated in women of childbearing age.**    If your patient is currently prescribed any of the above contact the Specialist Community Perinatal Service for urgent advice and a medic will respond within 48hours | | | | | | | |
| BNSSG Specialist Community Perinatal Service  The Coppice, Callington Rd Hospital, Marmalade Lane, Brislington, Bristol BS4 5BJ  T: 01179195826 E: [awp.perinatalmentalhealthservice@nhs.net](mailto:awp.perinatalmentalhealthservice@nhs.net) | | | | | | | |

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# Working In Partnership for Perinatal Mental Health Across BNSSG