**Buckinghamshire Perinatal Mental Health Team
*Referral Form***

Tel:01865901749 (Mon-Frid, 09.00-17.00hrs
Tel: 01865902000 Out of Hours/Bank Holidays
 Email: oxfordhealth.bperinatalreferrals@nhs.net

***(Please complete all sections, failure to complete may result delay in your referral being processed)***

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| **URGENCY OF REFERRAL***(please tick)* |
| **Emergency***: I need patient assessed within 4hrs*  |  | **Urgent:** *I need patient assessed within 2 calendar days.* |  | **Routine:** *I need patient assessed within 14 calendar days.* |  |

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| **PERSONAL DETAILS** |
| **Full Name:** | **DOB:** | **NHS No:** |
| **Current Address (***including postcode***):**  | **Next of Kin or Emergency Contact** *(Name & Address):* **Relationship:Tel/Mobile No.:** |
| **Ethnicity:**  | **Interpreter Required? Y/N Contact Number(s):**  |
| **GP/REFERRER DETAILS** |
| **Registered GP Practice:** **GP Name:** **Address:** **Tel No.:** **Email:**  | **Referrer Details** *(if different from GP):* **Name:** **Address:** **Tel No.:** **Email:**  |
| **CHILDREN DETAILS** |
| **Name:** | **DOB/EDD:**  | **Gender:M/F** | **Name of School:** *(if school going age)***:** | **Resident With?**  | **Subject to Child Protection? Y/N** |
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| **REASON FOR REFERRAL** |
| **Reason for Referral:** *(****pre-conception, antenatal or postnatal?*** *Please also give a description of current mental health, difficulties and any issues around bonding and attachment)* |
| **Does patient agree to the referral? (Yes/No):**  |
| **RISK** |
| *(e.g. Thoughts of suicide, deliberate self-harm, neglect, thoughts of harming baby/children, any psychotic thoughts relating to baby/children/others; Estrangement/feeling estranged from infant bonding; domestic violence; children/adult safeguarding)* |
| **PSYCHIATRIC HISTORY** |
| *Depression* | *Severe Depression* | *Postnatal Depression* | *Anxiety* | *Bipolar Affective Disorder* |
| *Schizophrenia* | *Schizoaffective Disorder* | *Psychosis in Postnatal Period* | *Alcohol/Substance Misuse* | *Past Psychiatric Admissions* |
| ***Details:*** |
| **CURRENT MEDICATION***(Psychiatric/Physical)* |
| *(include date started and response)*  |
| **FAMILY MENTAL HEALTH HISTORY** *(tick if yes)* | *□ Partner □ Father □ Mother □ Sibling □ Client’s Child □Other* |
| Details (including Diagnosis) |
| **FAMILY HISTORY OF PERINATAL MENTAL ILLNESS** *(tick if yes)* | *□ Mother □ Grandmother □ Sister □ Aunt □ Daughter □ Other* *□ None* |
| *Details (including Diagnosis)* |
| **PHYSICAL/MEDICAL HISTORY**  |
| *(Any past and current physical health problems and treatment; relevant obstetric history; current obstetric plans -e.g. planned c-section, induction dates etc.)* |
| **OBSTETRIC HISTORY***(if pregnant at the time of referral)* |
| *Where is she receiving antenatal care? (does she attend and engage with maternity service)* |
| **Which hospital is she booked to deliver:**  | **Next Appointment:**  |
| **Gravida/Parity** | ***G*** |  | ***P*** |  |
| **DETAILS OF OTHER PROFESSIONALS INVOLVED** *(Health Visitor, Midwife, Community Midwife, Social Services, Obstetrician)* |
| **Name:** | **Title:** | **Service:** | **Tel No./Email:** |
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