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

Tel:01865901749 (Mon-Fri, 09.00-17.00hrs   
Tel: 01865902000 Out of Hours/Bank Holidays   
 Email: [oxfordhealth.bperinatalreferrals@nhs.net](mailto: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.* | | | | | | | | | | | |  |
| **TYPE OF REFERRAL** *(please tick)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Preconceptual:** |  | | | **Joint-working/In-reach:** | | | | | | |  | **Antenatal:** | | | | | | | | | |  | | **Postnatal:** | | | | | |  | |
| **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: Role of referrer:**  **Address:**  **Tel No.:**  **Email:** | | | | | | | | | | | | | | | | | | |
| **UNBORN CHILD/CHILDREN** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Expected Date of Delivery:** | |  | | | **Which hospital is she booked to deliver?** | | | | | | | | | |  | | | | | | | **Next Appointment:** | | | | | | |  | | |
| **Gravida/Parity** | | | | | | | **G** | | | | | |  | | | | | **P** | | | | | | | | | |  | | | |
| **CHILDREN’S DETAILS** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Name:** | | | **DOB:** | | | **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:** *Please include 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.)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **OBSTRETIC HISTORY**  *(if pregnant at the time of referral)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| *Where is she receiving antenatal care? (does she attend and engage with maternity service)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **DETAILS OF OTHER PROFESSIONALS INVOLVED** *(Health Visitor, Midwife, Community Midwife, Social Services, Obstetrician)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Name:** | | | | | | | | | **Title:** | | | | | | | **Service:** | | | | | | | | | **Tel No./Email:** | | | | | | |
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