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| **Buckinghamshire Perinatal Mental Health Team (BPNMHT) & Maternal Mental Health Service (MMHS)  Referral Form** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Date of Referral:** | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | |
| **Please indicate if you had**  (*please tick*): | | | | **Face to face Consultation** | |  | | **Digital Consultation** | | | | | |  | | | **Phone Consultation** | | | | |  | **Date of  Consultation** | | | | | |  |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **IMPORTANT:**  **\*All referrals should be submitted to:** [**bperinatal.referrals@oxfordhealth.nhs.uk**](mailto:bperinatal.referrals@oxfordhealth.nhs.uk). **\*Telephone numbers:**  01865 901749 (Mon to Fri, 09.00-17.00hrs) & 01865 902000 (Out of Hours/Bank Holidays).  **\*Any referrals received after 16:00hrs will be dealt with next working day unless emergency.**  \***Website**: [**https://www.oxfordhealth.nhs.uk/buckinghamshire-perinatal-mental-health-service/**](https://www.oxfordhealth.nhs.uk/buckinghamshire-perinatal-mental-health-service/)  \*Please contact our clinicians to discuss with you the appropriateness of any referral that you are considering making to the service.  \*Contact with a patient is required before making a referral to the team.  \*Please ensure that you have read the guidance for referrers attached below before completing this form.  \*Please complete all sections, as failure to do so may result in a delay with your referral being processed.  \*All MMHS referrals must include a completed *Fear of Birth Scale (FOBS),* which is included at the end of this form. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **URGENCY  OF**  **REFERRAL**  (please tick) | | ***Emergency*** *– an unexpected, time critical situation that may threaten the life, long-term health, or safety of an individual or others and requires an immediate response.* ***(I need patient assessed within 4hrs)*** | | | | | | | | | | | | | | | | | | | | | | | | |  | | |
| ***Urgent*** *– a serious situation and an individual may require timely advice, attention, or treatment, but is not immediately life-threatening.* ***(I need patient assessed within 2 calendar days.)*** | | | | | | | | | | | | | | | | | | | | | | | | |  | | |
| ***Routine -*** *a woman with a complex or severe mental health problem (known or suspected) who needs assessment but there are no imminent risks of harm.*  ***(I need patient assessed within 14 calendar days.)*** | | | | | | | | | | | | | | | | | | | | | | | | |  | | |
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| **TYPE OF REFERRAL** (please tick) | | **Antenatal** | | | | | | | | | |  | | | **Postnatal** | | | | | | | | | | |  | | | |
| **Maternal Mental Health Service** | | | | | | | | | |  | | | **Preconceptual** | | | | | | | | | | |  | | | |
| **Joint-working/In-reach** | | | | | | | | | |  | | |  | | | | | | | | | | | | | | |
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| **PATIENT DETAILS** | | **Full Name:** | | | | | | | | | | | | | **Current Address:** | | | | | | | | | | | | | | |
| **DOB:** | | | | | | | | | | | | |
| **NHS No:** | | | | | | | | | | | | |
| **Language:** | | | | | | | | | | | | | **Tel/Mobile No:** | | | | | | | | | | | | | | |
| **Ethnicity:** | | | | | | | | | | | | | **Email:** | | | | | | | | | | | | | | |
| **Interpreter Required? Y/N:** | | | | | | | | | | | | | **Religion:** | | | | | | | | | | | | | | |
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| **NEXT OF KIN/ EMERGENCY CONTACT** | | **Full Name:** | | | | | | | | | | | | | **Current Address** *(if different from patient’s)*: | | | | | | | | | | | | | | |
| **Relationship:** | | | | | | | | | | | | | **Tel/Mobile No:** | | | | | | | | | | | | | | |
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| **GP DETAILS** | | **GP Name:** | | | | | | | | | | | | | **Registered GP Practice (***inc. full address)* | | | | | | | | | | | | | | |
| **Tel No:** | | | | | | | | | | | | |
| **Email:** | | | | | | | | | | | | |
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| **REFERRER DETAILS** | | **Full Name:** | | | | | | | | | | | | | **Address** *(inc. full postcode)*: | | | | | | | | | | | | | | |
| **Tel No:** | | | | | | | | | | | | |
| **Role of Referrer:** | | | | | | | | | | | | |
| **Email:** | | | | | | | | | | | | |
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| **UNBORN CHILD /CHILDREN** | | **Estimated Due Date** *(in current pregnancy):* | | | | |  | | **Which hospital they booked to deliver?** | | | | | | | | |  | | **Next Appointment:** | | | | | | | |  | |
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| **CHILDREN’S DETAILS** | | **Name:** | | | | | | | | |  | | | | | | | |  | | | | |  | | | | | |
| **DOB:** | | | | | | | | |  | | | | | | | |  | | | | |  | | | | | |
| **Gender (M/F):** | | | | | | | | |  | | | | | | | |  | | | | |  | | | | | |
| **Name of School** *(if applicable)***:** | | | | | | | | |  | | | | | | | |  | | | | |  | | | | | |
| **Resident With?** | | | | | | | | |  | | | | | | | |  | | | | |  | | | | | |
| **Subject to Child Protection? Y/N** | | | | | | | | |  | | | | | | | |  | | | | |  | | | | | |
| **REASON FOR REFERRAL** *(Please include a description of current mental health, difficulties and any issues around bonding and attachment)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **RISK (Historic/Current)**  *(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)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **PSYCHIATRIC HISTORY**  *(e.g., Depression, Postnatal Depression, Severe Depression, Anxiety, Bipolar Affective Disorder, Psychosis in Postnatal Period, Schizophrenia, Schizoaffective Disorder, Alcohol/Substance Misuse, Past Psychiatric Admissions)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **CURRENT MEDICATION**  *(Psychiatric/Physical; include date started and response)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **FAMILY MENTAL HEALTH HISTORY** (*Details including Diagnosis) (Partner, Father, Mother, Sibling, Client’s Child or Other)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **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.)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **OBSTRETIC HISTORY** | | | **Gravida** (number of pregnancies): | | | | | | | | | |  | | | **Parity** (number of deliveries): | | | | | | | | | | | | |  |
| **PREVIOUS TRAUMA OR LOSS** | | | **Previous traumatic birth? (Y/N)** | | | | | | | | | |  | | | **Previous perinatal loss? (Y/N)** | | | | | | | | | | | | |  |
| **DETAILS OF OTHER PROFESSIONALS INVOLVED** *(Health Visitor, Midwife, Community Midwife, Social Services, Obstetrician)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Name** | | | | | **Role** | | | | | **Service** | | | | | | | | | | | **Tel No./Email** | | | | | | | | |
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| **Fear of Birth Scale (FOBS) PLEASE COMPLETE FOR ALL MMHS REFERRALS**  **Please complete with the woman/birthing person** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| *“How do you feel right now about the approaching birth?  Please mark with an* ***X*** *on the lines below.*  *This should be your initial/instinctive reaction if possible”*   |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | **Calm** |  |  |  |  |  |  |  |  |  |  | **Worried** |  1. **100**  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | **No Fear** |  |  |  |  |  |  |  |  |  |  | **Strong Fear** |  1. **100**   *If completing digitally and submitting with the referral, please either mark with an X or specify in writing the chosen value for each scale e.g. Calm/Worried = 80; Fear = 50).* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **CONSENT TO REFERRAL** | Has the woman/birthing person consented to this referral? **(Y/N)** | | | | | | | | | | | | | | | | | | | | | | | |  | | | | |
| Is the client aware that by consenting to this referral, they are also consenting to us discussing these details with other services if we feel that they may be more appropriate to offer support? **(Y/N)** | | | | | | | | | | | | | | | | | | | | | | | |  | | | | |
| Does the client consent to answerphone messages and/or text messages being left on the contact number provided? **(Y/N)** | | | | | | | | | | | | | | | | | | | | | | | |  | | | | |

**Guidance for Referrers**

**Buckinghamshire Perinatal Mental Health Team (BPNMHT)**

***Who Is This Service For?***The Buckinghamshire Perinatal Mental Health Team is a specialist service providing assessment and treatment to women/birthing persons with complex and severe mental health problems during pregnancy and up to one-year post-birth.

The service offers specialist perinatal mental health assessments, which focus on both the needs of mother and infant. The team will consider the support options for women/birthing persons suffering with severe mental illness such as severe depression or anxiety, Post-Traumatic Stress Disorder, Bipolar Affective Disorder, Schizophrenia, Schizoaffective Disorder and Post-Partum Psychosis. It can also support women/birthing persons with a history of severe mental illness who are planning a pregnancy, or who have become pregnant and are at high risk of relapse during pregnancy or the postnatal year.

1. ***Who/When Should I refer?***
2. ***“Admission vulnerable” women/birthing persons who are pregnant and/or up to one year postpartum:***

* With current moderate to severe symptoms of a depressive illness, anxiety disorder (e.g. OCD, GAD, birth trauma and possible PTSD, tokophobia, health anxiety) emotional instability / emotionally unstable personality disorder (EUPD), bipolar disorder (BPAD) or psychotic illness
* With Significant associated distress, negative impact on daily functioning and/or bonding and attachment issues with unborn or baby (e.g. poor social functioning, social isolation, not connecting with or wanting baby, self-neglect/poor self-care, social care involvement or concerns)
* Women/birthing persons with an established/confirmed diagnosis of BPAD, schizophrenia, schizoaffective disorder, previous psychotic depression, or previous puerperal psychosis (even if currently well).
* Experiencing sudden onset of psychotic symptoms (hallucinations, delusions, lability of mood) especially in the first 4 weeks after birth
* Sudden onset of new mental health difficulties, especially between 28 weeks gestation and 6 weeks post-partum

1. ***Women/Birthing Persons Who Are Existing Community Mental Health Team (CMHT) Patients and require:***

* Pre-conception advice (usually a one-off appointment)
* Medication advice in the perinatal period
* Joint working: in-reach for perinatal-specific disorders including post-natal depression, puerperal psychosis, bipolar disorder and other severe mental illness
* Specialist input around Birth Trauma (on a case-by-case basis to be discussed with the Perinatal Psychologist)

1. ***Other Presentations:***

* Pre-conception advice for women/birthing persons who wish to conceive and who are identified as being high risk (diagnosis severe mental illness and/or family history of psychosis) and/or require specialist information about medication in pregnancy
* Concealed pregnancy. Consider referral using clinical judgment if no antenatal care booked over 24 weeks.

**Women/birthing persons who are open to Community Mental Health Team (CMHT) or Child and Adolescent Mental Health Services (CAMHS) or other CMHT/CAMHS-based service (e.g. Learning Disability, Early Intervention Psychosis, Eating Disorders) should remain with that team. This includes women/birthing persons who are open/receiving secondary care psychology or outpatient psychiatry review within that CMHT (this may be discussed on a case-by-case basis).**

1. ***What Does the Service Offer?***

***Core aspects of support/interventions offered by the service include:***

* Psychiatric assessment and care of women/birthing persons who are pregnant and at risk of developing mental ill health following and prescribing medication, if needed
* Advice on the risks and benefits of using psychotropic medication during pregnancy and when breastfeeding  
  Pre-conception advice to women/birthing persons with current or previous serious/complex mental ill health who are considering pregnancy
* Support with developing the mother and baby relationship
* Psychological therapies including Cognitive Behavioural Therapy, Interpersonal Psychotherapy, EMDR (Eye Movement Desensitisation Reprocessing) and Relapse-Prevention Work
* Parenting skills support including help with mother-infant activities, routine and role adjustment  
  Expert advice to non-specialist services
* Assessment will be offered up until 12 months postnatally to identify an appropriate care pathway
* Providing care across Buckinghamshire to women/birthing persons in their own homes wherever possible, enabling them to maintain their roles as mothers while their mental illness is safely treated.
* Working closely with other professionals, developing a treatment plan tailored to individual needs in close partnership and collaboration with the woman/birthing person and their family

**Maternal Mental Health Service (MMHS)**

1. ***Who is this Service For?***

The Maternal Mental Health Service is a specific care pathway within the Perinatal Mental Health Team. It offers psychological therapy and support for currently pregnant women/birthing persons who are experiencing moderate to severe anxiety and psychological distress directly related to pregnancy and childbirth.

Moderate to severe symptoms of childbirth-related anxiety means that the person’s difficulties are likely to be at a level that significantly affects their day-to-day life and functioning, including their emotional and physical experience of current pregnancy and their decision-making regarding subsequent labour and birth. There will often be avoidance of things related to childbirth, including talking about it, attending antenatal classes and appointments, watching programmes, or reading materials associated with birthing. Many women/birthing persons will request caesarean section, whether or not there is medical/obstetric indication for this, in order to avoid the prospect of vaginal delivery which may be perceived as a less predictable event.

1. ***Who Should I Refer?***

***Women/Birthing Persons who meet all the below criteria:***

* Currently pregnant and receiving antenatal care within BHT
* Experiencing moderate to severe levels of fear and anxiety directly related to pregnancy and childbirth
* Score 60 or above on the Fear of Birth Scale (FOBS)

1. ***Who Can Make a Referral?***

***At present, all MMHS referrals must come through one of the following channels:***

* Consultant Midwife (within Bucks maternity services)
* Specialist MH Midwife (within Bucks maternity services)
* Bucks Perinatal Mental Health Team, following MDT discussion