

**Referral to Hampshire**, **Portsmouth, Isle of Wight and Farnham** **Perinatal Mental Health Service**

**Perinatal Mental Health Service**

Melbury Lodge Romsey Road Winchester

Hants SO22 5DG

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

Tel: 01962 897780

Fax: 01962 897781

**Please note that we cannot provide urgent or emergency services.**

**SECTION 1 – Personal details:**

Name (inc title): ......................................................................................................................................................

Current address including postcode: .......................................................................................................................

...............................................................................................................................................................................

Telephone: (mob) ............................................................ (landline) .....................................................................

D.O.B:............................................................................. NHS No: ......................................................................

Ethnicity:......................................................................... Preferred language: .....................................................

Interpreter required: Yes: No:

Religion: ......................................................................... Occupation:.................................................................

Important others: (Partner/family/main carer) ..........................................................................................................

**Next of Kin**

Name (inc title): ......................................................................................................................................................

Relation (i.e. husband, mother, etc): ........................................................................................................................

Address including postcode: ...................................................................................................................................

Telephone: (mob) ............................................................ (landline) .....................................................................

**Date of Referral: \_ \_ / \_ \_ / \_ \_ \_ \_**

Has this woman consented for the following information to be shared with the Perinatal service and for the Perinatal service to make contact?

Yes: **Please be aware we will not process the referral unless this box is ticked.**

**SECTION 2 – Baby and Child details:**

**SECTION 3 – Details of Agencies involved:**

**GP:** (Name, address, telephone number):

**Community Mental Health Team:**

(Name, address, telephone number):

**Health Visitor:** (Name, address, telephone number):

**Obstetric Team** if applicable: (Name, address, telephone number):

**Midwife:** (Name, address, telephone number):

**Social Services** if applicable: (Name, address, telephone number):

**Referrer**

Name:............................................................................. Address: ......................................................................

...............................................................................................................................................................................

Telephone: ...................................................................... Date of referral: ...........................................................

Baby’s full name:............................................................. D.O.B: .........................................................................

EDD if pregnant: ............................................................. Planned place of delivery?: ..........................................

Any other children including names / age / D.O.B:...................................................................................................

............................................................................................................................................................................... Baby’s / Children’s Father’s full name: ......................................................................................................................

Who has parental responsibility? .............................................................................................................................

**SECTION 4 – Reason for referral:**

Past psychiatric history including previous diagnosis, admissions and treatment:

Current medication, response and dates started:

None: (Tick)

Any other current treatment: (Eg: IAPT - ITalk, Steps to Wellbeing etc, CMHT involvement):

**Is this a new onset condition arising after 28 weeks pregnancy and before 6 weeks post partum?**

**Yes: No:**

**If yes,** we will contact referrer or the woman within two working days.

Please give a description of the woman’s current mental health and difficulties and any issues around bonding and attachment:

**SECTION 5 – Physical health:**

**SECTION 6 – Risk:**

Current risk to self: (e.g. thoughts of suicide, deliberate self-harm, neglect):

Current risk to others: (e.g. thoughts of harming baby or children, any delusional beliefs involving baby or children or others):

Any current risk from others (e.g. domestic violence, adult safeguarding):

Any current drug or alcohol use? (please give details):

Any child protection concerns past or present: No: Yes: If yes, please give details:

Any past or current physical health problems and treatment:

Any relevant obstetric history (including previous birth trauma):

Any current obstetric plans (e.g. planned C-section, induction dates, etc.):

Please send this form and any other information to:

Post: **Perinatal Mental Health Service,** Melbury Lodge, Romsey Road, Winchester, Hants SO22 5DG

Email: **PerinatalReferrals@southernhealth.nhs.uk**

**Emergency and out of hours referrals: please contact your local Acute Mental Health Team / Crisis Team, Tel Nos.**

* **East Hampshire Team** (Elmleigh, Havant):........................ **023 9234 4562**
* **North Hampshire Team** (Parklands, Basingstoke): ........... **01256 316300/01256 817718**
* **West Hampshire Team** (Melbury Lodge, Winchester):...... **01962 897726**
* **Southampton Team** (Antelope House, Southampton): .... ..**023 8083 5535 or 023 8083 5552**
* **Isle of Wight**: ...................................................................... **01983 522214**
* **Portsmouth City**: ............................................................... **0300 123 3924**
* **North East Hampshire and Farnham**:...............................**0300 456 8342**

**and notify us immediately**

Please give details of any past history of any of the above risks including dates: