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

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| --- |
| **Please complete all sections, failure to complete may result in delay in your referral being processed.**  **Please note that we cannot provide urgent or emergency services.**  Please send the referral form via eRS or email this form and any other information to: [**Perinatalreferrals@southernhealth.nhs.uk**](mailto:Perinatalreferrals@southernhealth.nhs.uk)  If you wish to discuss your referral prior to submitting it, please call: **01962 897780** |

[ ]

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.

Date of Referral:

SECTION 1 – Personal details:

|  |  |  |  |
| --- | --- | --- | --- |
| **Name:** |  | |  |
| **Current address**  **including postcode:** |  | |  |
| **Telephone Mobile:** |  | **Telephone Home:** |  |
| **D.O.B:** |  | **NHS No:** |  |
| **Email address:** | | **Language:** |  |
| **Ethnicity:** | | **Interpreter required:** | Yes [ ] No [ ] |
| **Religion:** | |
| **Next of Kin** |  | |  |
| **Name (inc. title):** |  | | |
| **Telephone:** |  | | |
| **Relation (i.e., husband, mother, etc):** |  | | |
| **Address including**  **postcode:** |  | | |

SECTION 2 – Baby and Child details: Please enter N/A in either Baby’s Name or EDD which ever does not apply

|  |  |  |  |
| --- | --- | --- | --- |
| **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 3 – Details of Agencies involved:

|  |  |  |  |
| --- | --- | --- | --- |
| **Referrer** |  | | |
| **Referring**  **Clinician:** |  | **Role:** |  |
| **GP Practice:** |  | **Telephone:** |  |
| **Address:** | | | |
| **Other professionals involved (HV, GP, Midwife, CMHT etc):** | | | |
|  | | | |

SECTION 4 – Reason for referral:

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| Please give a description of the woman’s current mental health and difficulties, and any issues around bonding and attachment. Please include any relevant physical health or obstetric information: |
| Current medication and dates started:  None: [ ] (mark with x)  **Is the woman breastfeeding?** Yes [ ] No [ ]  Any other current treatment: (e.g. IAPT - iTalk, Steps to Wellbeing etc, CMHT involvement): |

SECTION 5 – Risk:

|  |
| --- |
| **Does the women have? Please answer Yes or No, if YES please give details** |
| **A recent significant change in mental state or emergence of new symptoms** **[ ]** |
| **New thoughts/act of suicide or self-harm? [ ]** |
| **New and persistent expressions of incompetency as a mother or estrangement from the infant?** **[ ]** |
| Any other risks, including safeguarding, risk to self, risk from others etc. |

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

Website for Southern Health teams: [Help in a crisis: Southern Health NHS Foundation Trust](https://www.southernhealth.nhs.uk/help-crisis)

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 PMHT immediately.