Referral Form

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| **SERVICE USER DETAILS (please read eligibility criteria below before completing form)** | | | |
| **Name** |  | **Date of Birth** |  |
| **Address** |  | **GP Practice** |  |
| **Post Code** |  | **NHS Number** |  |
| **Telephone** |  | **Ethnicity** |  |
| **Consent for voicemail/ text message** |  | **Language** |  |
| **Email** |  | **Interpreter required?** |  |
| **REFERRER DETAILS** | | | |
| **Name** |  | **Contact no.** |  |
| **Service** |  | **Email** |  |
| **Position** |  | **Date of referral** |  |
| **CONSENT** | | | |
| Ensure that the service user has consented to the referral and understands that their clinical information may be discussed in front of the wider MDT, including health professionals who may not be directly involved in their care  **Does service user consent to the referral? YES/NO** | | | |
| Please note that we will also anonymise service user data and use it for research/evaluation purposes, which may include sharing it with external parties. Service users will not be identifiable from any of the data shared for these purposes  **Please confirm if the service user agrees to their anonymous data being shared YES / NO** | | | |
| **NEXT OF KIN/PARTNER** | | | |
| **Name** |  | **Relationship** |  |
| **Contact details:** | | | |

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| **REFERRAL INFORMATION** | | | | | | | |
| **Obstetric History** | | No. of previous pregnancies | | | | No. of children | |
| **Perinatal Information (Not required if reason for referral is loss)** | | | | | | | |
| **Preconception Y/N** | | **Antenatal Y/N** | | | | **Postnatal Y/N** | |
| **Expected due date** |  | | **Current gestation** |  | **Date of birth of baby/ babies** | |  |
| **Reason for referral / Presenting problem (please see eligibility criteria attached)** | | | | | | | |
| **Traumatic birth Y/N** | | | | **Loss of baby Y/N** | | | |
| **PTSD due to neonatal experience Y/N** | | | | **Severe fear of childbirth Y/N** | | | |
| **Severe fear of foetal medicine/medical interventions impacting on pregnancy Y/N** | | | | **Removal of baby at birth Y/N** | | | |
| **Please provide details: *(current mental health symptoms, details of the event, impact on daily activities etc.)*** | | | | | | | |
| **How does the service user rate the level of impact of their difficulties on their daily functioning?** | | | | | | | |
| **0 1 2 3 4 5 6 7 8 9 10**  **No impact Severe impact** | | | | | | | |
| **RISK FACTORS** | | | | | | | |
| **First 4 weeks postpartum Y/N** | | | | | | | |
| **Sudden deterioration of mental health or emergence of new symptoms Y/N** | | | | | | | |
| **New thoughts of violent method of suicide or acts of self-harm Y/N** | | | | | | | |
| **New, persistent expressions of incompetency as a mother, or feeling estranged from infant Y/N** | | | | | | | |
| **Thoughts of running away Y/N** | | | | | | | |
| **Previous history of self-harm/suicide Y/N** | | | | | | | |
| **Current substance misuse Y/N** | | | | | | | |
| **Thoughts of harm to child Y/N**  **(Any thoughts of harm to child or psychotic thoughts relating to child increases risk)** | | | | | | | |
| **Current risk to self (e.g. thoughts of suicide, deliberate self-harm, self-neglect)**  **Y/N** | | | | | | | |
| **Current risk to others (e.g. thoughts of harming child/children) Y/N** | | | | | | | |
| **Current risk from others Y/N** | | | | | | | |
| **Does the woman have a personal history of:** | | | | **Does the woman have a family history of:** | | | |
| **Bipolar Disorder Y/N** | | | | **Bipolar disorder Y/N** | | | |
| **Postpartum Psychosis Y/N** | | | | **Postpartum psychosis Y/N** | | | |
| **Other psychotic disorder Y/N** | | | | **Other severe disorder Y/N**  **If so, please provide details:** | | | |
| **Severe depressive disorder Y/N** | | | |
| **\*If risk factors identified, please consider whether a referral to SPCMHT/HTT/Mental Health Liaison is necessary in the first instance as we are not an urgent service\*** | | | | | | | |
| **Please provide details:** | | | | | | | |

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| **ADDITIONAL INFORMATION** |
| **Current Medication** |
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| **Any other professionals involved in the service user’s care currently? (e.g. Mental health professionals, midwife, obstetrician, social worker etc.)** |
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| **Any safeguarding issues/ alerts (e.g. Child Protection, Adult Support and Protection etc.)** |
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| **Has the service user been known to mental health services in the past?**  **If so, please provide details:** |
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| **Does the service user have any difficulties, or social factors, that may impact on them attending / engaging in regular appointments?** |
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**Please ensure the referral form is fully completed – if you would like to discuss a case prior to making a referral, please call the service on 0300 013 2082 and ask to speak to a member of the team.**

**Please send competed referral form to** [**bfwh.mmhservice@nhs.net**](mailto:bfwh.mmhservice@nhs.net)

Eligibility & Exclusion criteria

**Eligibility**

Referrals will be considered for women aged over 16 years of age who are experiencing **moderate to severe** symptoms of post-traumatic stress/ significant psychological distress due to a severe fear of childbirth, or as a **direct** consequence of a traumatic reproductive/maternity experience or loss, which could have occurred at any time. This may include the following presentations:

* Traumatic birth
* Loss of baby through intra-uterine death, still birth, early miscarriage, recurrent miscarriage, early infant death (up to 3 months), failed IVF or termination of pregnancy for any reason
* PTSD as a result of Neonatal Unit experience
* Severe fear of childbirth (tokophobia)
* Severe fear of foetal medicine/ medical interventions, impacting on pregnancy
* Removal of baby at birth (or up to 3 months after if baby admitted to neonatal unit/remains in hospital)

The service will be provided to women who live in Lancashire and South Cumbria and who are willing and able to engage in a form of brief psychological intervention offered by the service.

(Moderate to severe symptoms refer to difficulties which are at a level that mean day to day functioning and / or the new parenting relationship is significantly affected)

**Exclusions**

* Service users presenting with mild to moderate symptoms associated with trauma
* Service users who may benefit from a therapeutic intervention provided by IAPT or third sector services in the first instance
* Service users whose presenting difficulties are related to longstanding issues related to complex/childhood trauma
* Significant psychosocial, physiological and safety issues are evident (e.g. homelessness, finances, physical illness, severe self-neglect, impulsive or risk taking behaviour) which would prevent patient from engaging in therapy at this time
* Service user and their presenting problem requires a multi-agency and psychiatric approach to care, that could be longer term, and would best be facilitated within the Specialist Perinatal Community Mental Health Team.
* Significant risk issues identified which could indicate current risk to self or others (e.g. perinatal red flags)
* Significant risk issues that may be exacerbated as a result of engaging with therapy
* Currently engaging in significant drug or alcohol use