Southern Health and Social Care Trust

# Perinatal Mental Health Service Referral Form

IF YOU WOULD LIKE TO DISCUSS A REFERRAL FIRST PLEASE CONTACT;

URSULA TUMELTY CLINICAL LEAD 07384871350
LEANNE ARMSTRONG, MIDWIFE 07825010366
MARY MAGEE, HEALTH VISITOR 07553586878
Perinatal Team general enquires-02837 565310 (65310) internal extension.

Please telephone to discuss **URGENT** referrals with Ursula Tumelty Clinical Lead

Please return completed Referral Form via email to:

PerinatalMHT@southerntrust.hscni.net

| **Referral type** *(Please select)* | |
|---|---|
| Urgent ☐<br>*(please phone team to discuss)*<br><br>Routine ☐ | Antenatal ☐<br><br>Postnatal ☐<br><br>Pre-conceptual Counselling ☐ |

**PLEASE COMPLETE FORM FULLY** - Forms with insufficient information cannot be accepted

| **Patient Details** *(Please enter details legibly)* | | | |
|---|---|---|---|
| Title | | **EDD / DOB of baby *Please Complete*** | |
| Full Name | | | DOB |
| Address | | | Postcode |
| Mobile Number | | Landline Number | |
| HCN | | Interpreter Required | Yes / No |
| Ethnicity | | Primary Language | |
| NOK Name | | NOK Phone Number | |
| **GP Details** | *please enter details legibly* | | |
| GP Name | | | |
| GP Address | | | |
| GP Tel Number | | | |
| **Referrer Details** | *please enter details legibly* | | |
| Referrer Name | | | |
| Referrer Title | | | |
| Referrer Address | | | |

| | |
|---|---|
| Tel Number | |

| **Details of professional currently involved (provide name, location and contact details)** | |
|---|---|
| Midwife | |
| Health Visitor | |
| Obstetrician | |
| Social Worker | |
| Other | |
| Child Protection/Adult Safeguarding | |
| **Where will patient deliver** | |

**Reason for Referral (consider emergence of new symptoms, new thoughts or acts of violent self-harm, feelings of incompetence or estrangement from baby, please include diagnosis (if known))**

**Medication (if known)**

**Risk Factors Relating to Psychiatric History** (Please select one)

New onset illness suggesting the presence of a psychotic or severe depressive illness ☐

Established Diagnosis of Serious Mental Illness ☐

Past History of pregnancy related mood disorder ☐

Past History of pregnancy related psychotic disorder including Puerperal Psychosis ☐

Please give details:

**Risk Factors Relating to Personal History**

History of substance abuse Y / N / Unknown

History of aggressive behaviour Y / N / Unknown

History of self-harm or suicidality Y / N / Unknown

Please give details:

**Risk Factors relating to Family History of Serious Mental Illness** (select all that apply)

Family History of Bipolar Affective Disorder ☐

Family History of Puerperal Psychosis ☐

Other Family History ☐

Please give details:

**Previous history of contact with psychiatric services including admission** (select all that apply)

Admission to Acute Mental Health Inpatient Unit ☐ Admission to Home Treatment Team ☐

Previously known to Perinatal Mental Health Team ☐ Known to Community Mental Health Team ☐

Other ☐

Please give details:

| **Is the woman in agreement with referral to Perinatal Mental Health Team?** | **Yes / No** |
|---|---|

| **Has this woman been referred to social work services** | **Yes / No** |
|---|---|

| **Date of Referral** | |
|---|---|

[redacted]

*Please read and check that all details have been completed, particularly EDD*