

Referral to Coventry and Warwickshire Perinatal Mental Health Team

For PMHT: women aged 16 years and over

Date of Referral:

Hospital No.:

NHS No.:

Patient consent given? Yes No

DOB:

Consultant Obstetrician (if applicable)

Weeks Pregnant
/40

Parity:

Due Date:

Ethnicity

Language Spoken:

Date Delivered:

Interpreter Required Yes No N/A

PATIENT INFORMATION

Surname:

Forename:

Address:

Post Code



REFERRER DETAILS

Name:

Designation:

Address:

Post Code



GENERAL PRACTITIONER DETAILS

Name:

Surgery

Address:

Post Code



- Psychotic Symptoms Strong suicidal thoughts or plans Hostile thoughts about baby with intent to harm the baby

If any of the above is present, at any stage of pregnancy or up to 1 year postnatally, complete the form urgently and email or phone it to:

PMHT - Monday - Friday 9am - 5pm email: pmht@covwarkpt.nhs.uk / telephone: 024 7621 2176

Out of working hours, tel: 08081 966798 / email: MHreferrals@covwarkpt.nhs.uk Open 24/7.

Current Symptoms – Please tick relevant boxes

The perinatal team will consider patients who have these issues **beginning perinatally** (i.e. in pregnancy or 1 year postnatally):

- Severe bonding issues / mother-infant attachment issues
 - Severe depressive illness
 - Moderate to severe depression or low in mood
 - Occasional suicidal thoughts –but no real plans
 - Significant change in mood, including elevated mood
 - Moderate to severe anxiety-based disorders
 - Obsessive compulsive symptoms
 - Anxiety/panic attacks
 - Fears she may harm baby (no intent)
 - Tokophobia (fear of childbirth)
 - Requests for elective c-section with no medical indication
 - Requests for elective c-section with background of mental illness (Coventry/Rugby only)
 - Labour or postnatal related post-traumatic symptoms
 - Past postnatal depression requiring hospitalisation
 - Past severe postnatal depression, no hospitalisation
 - History of psychosis (may be postnatal or not)
- Experiencing moderate to severe distress as a result of perinatal or infant loss (infant up to 23 months) **If your referral is for loss, please also completed loss pathway referral information box**
- Or prior to conception** with a history of schizoaffective disorder, bipolar disorder or severe depressive illness requiring hospitalisation

Other relevant facts

Current social issues:

- Partner has a serious mental illness (as above)
- Feels socially isolated
- Child protection involvement with any child
- Current domestic violence

History of: (and give details overleaf - essential)

- Non postnatal depression
- Non postnatal mania / hypomania
- Self-harm attempts in the past 2 years
- Eating disorder
- Other psychiatric illness – diagnosis (specify)
- Family history of first degree relative with bi-polar, psychotic illness e.g. schizophrenia, severe postnatal depression or postpartum psychosis
- Past domestic violence

Outcome Measures Results (if known)

Edinburgh Postnatal Depression Scale: _____

Hospital Anxiety and Depression Scale: _____

GAD-2: _____

Whooley question 1: Yes No

Whooley question 2: Yes No

Whooley question 3: Yes No

Past mental health history – Please include any episodes of perinatal mental illness including postnatal depression or psychosis, outpatient, inpatient or day care and dates including treatments given and by whom (if known)

Current psychiatric or mental health care – i.e. Brief History / Name of Psychiatrist or Therapist

Current medication (all)

Physical health problems (Past/Present)

Social circumstances

Partner/Husband	Yes	No	Children living with patient	Yes	No	<i>If yes, please give details below:</i>
Partner living with patient	Yes	No				
			Child Name			Age / Date of Birth
			Child Name			Age / Date of Birth
			Child Name			Age / Date of Birth

Please detail any current social stressors:

Any history of threatened or actual violent or aggressive behaviour in the household

Names & designation of other involved professionals e.g. Health Visitor, Social Worker, Midwife, CPN

Name	Name
Designation	Designation

Reason for referral to the Perinatal Service?

Please complete box below if referral is for loss pathway

Please complete CORE10 before referral – *please refer only if 15 or above.*

IMPORTANT – PLEASE READ THIS FIRST

This form has 10 statements about how you have been OVER THE LAST WEEK.
Please read each statement and think how often you felt that way last week.
Then choose the button which is closest to this.
Please remember to save the file when you are finished.

Over the last week

Not at all Only Occasionally Often Most or all
Sometimes the time

1. I have felt tense, anxious or nervous
2. I have felt I have someone to turn to for support when needed
3. I have felt able to cope when things go wrong
4. Talking to people has felt too much for me
5. I have felt panic or terror
6. I made plans to end my life
7. I have had difficulty getting to sleep or staying asleep
8. I have felt despairing or hopeless
9. I have felt unhappy
10. Unwanted images or memories have been distressing me

Score on CORE10:

Type of loss: miscarriage, ectopic pregnancy, Termination for medical reasons, stillbirth, neonatal loss, infant loss, other (please specify)

Date of loss(es):

Name of baby/babies (if known)

Age/gestation at time of loss:

How is the loss affecting the person referred?:

Signature of referrer

Name in BLOCK CAPITALS

Date:

Disclaimer:

Please ensure all referrals containing confidential information are sent via secure email to PMHT

 Please return this form to

Email: PMHT@covwarkpt.nhs.uk
(Telephone: 024 7621 2176)

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