

**Perinatal Mental Health Community Service (PMHCS)**

**(Professional referral form)**

Perinatal Specialist Appointments provide a valuable space for patients, *alone or with* their healthcare professionals, to access expert advice and support in all aspects of perinatal mental health care, including psychological well-being, mental health, medication, navigating local support services, and parent-infant relationships.

These meetings may serve as a one-off opportunity to formulate and make recommendations for the person, for their supporting care professionals, signposting, or an offer of MDT support within PMHCS.

PMHCS welcomes referrals requesting a Perinatal Specialist Appointments between PMHCS and:

* Women/birthing people with perinatal mental health concerns
* Women/birthing people and their healthcare professional/referrer
* Women/birthing people transitioning from NICU/MBU back home
* Preconception advice for those with mental health concerns wishing to become pregnant

For those triaged as having social and mental health complexities (e.g. the baby is at risk of being removed), a trauma-informed professionals meeting may be offered in the first instance. Within this meeting, it will be discussed as to whether PMHCS is appropriate to engage further.

In the event of loss of pregnancy, when open to PMHCS, the service will continue to support the person until a more appropriate service becomes available.

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| **Perinatal Mental Health Community Service (PMHCS) Professional Referral form**  |  |
| **You can contact us via telephone on 01622 722321 or 01227 768928or you can email us: kmpt.pmhcs@nhs.net** |
| **If the referral is considered urgent (a response within 4 hours) please call 01622 722321 and email the referral so this can be prioritised** **PMHCS criteria and further information can be found at www.kmpt.nhs.uk/pmhcs** |
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| **Referral Type:** *(please tick)* |
| * Meeting with patient and their healthcare professional/referrer for consultation
* Discharge from …
* Standard referral (patient and PMHCS staff to meet without referrer)
* Preconception advice
 | □□ NICU □ MBU□□ |
| **Details of person being referred:** *(please ensure details are legible)* |
| **Date referral made:** |  | **Telephone number:** |  |
| **First name:** |  | **Surname:** |  |
| **Date of birth:**  |  | **NHS number: (if known)** |  |
| **Address:** **Post code:** |  |
| **Does the person consent to:*** **Receiving text message reminders for appointments prior to initial assessment?**
* **Receiving email correspondence? (If yes, provide email address)**
* **Taking part in appointments/contact via online video link (Teams)?**
 | * □ Yes □ No
* □ Yes □ No

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| **Ethnicity:** |  | **Preferred language**: |  |
| **Interpreter required?**  | □ Yes □ No |
| **Next of Kin/Carer or Alternative contact:** *Providing this implies consent to contact*  |
| **Name:** |  | **Telephone number:** |  |
| **Relationship:** |  |
| **GP details:** |
| **Name:**  |  | **Telephone number:** |  |
| **Address:** **Post code:** |  |
| **Referrer details:** |
| **Name:**  |  | **Role:** |  |
| **Address:** **Post code:** |  |
| **Telephone number:** |  | **Email address:** |  |
| **Reason for referral**: |
| Professionals meeting with parent and HCP |  | Discharge from MBU/NICU |  | Preconception/prescribing advice during pregnancy/breastfeeding |  |
| Maternal mental health |  | Parent-infant difficulties |  | Anxiety |  |
| Psychosis/schizophrenia |  | Depression |  | Trauma/PTSD/c-PTSD |  |
| Personality disorder |  | Eating disorder |  | Tokophobia |  |
| Family/personal history of bi-polar/psychosis |  | Other (please give details) |  |
| Details: (brief summary of concerns, severity, context, strengths, and where relevant previous perinatal history) |
| **Is the patient aware of this referral?**  | □ Yes □ No |
| **Obstetric history:** |
| **Obstetrician:** |  | **Named Midwife:** |  |
| **EDD:** |  | **DOB of baby:** |  |
| **Gravida:** *(The number of times the woman is or has been pregnant, regardless of the pregnancy outcome)* |  | **Parity:** *(The number of pregnancies reaching gestational age / live births)* |  |
| **Children:** |
| **First name** | **Surname** | **Sex** | **DOB** | **Living where?** | **With who?** |
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| **Any past or current concerns including Child Protection?** | □ Yes □ No |
| **Has a referral been made to Children and Family Social Services?** | □ Yes □ No |
| **Have you identified any significant risks?** *(✓ if yes)* |
| Self-harm |  | Self-neglect |  | Vulnerability e.g. Learning Disability or adolescent |  |
| Suicidal ideation with intent/plan |  | Domestic violence |  | Exploitation |  |
| Domestic violence |  | Harm to baby |  | Harm to others |  |
| Substance misuse |  | Social stressors |  | Isolated |  |
| Medical-physical health or obstetric |  | Environmental Risks / Risks to Professionals (i.e. neighbourhood disputes, poor lighting, difficult access to property, aggressive animals) |  |
| Other (please give details) |  |
| Details: (brief summary of concerns, severity, context, and strengths) |