******Thrive – Psychological Support for Birth Trauma and Perinatal Loss Referral Form**

**Please read before completing the referral:**

* **Thrive does not provide care for urgent mental health needs or crisis intervention.** If you are concerned that the service user you are considering is experiencing an urgent mental health crisis please contact 111, and select option 2 when prompted for the Urgent Mental Health Helpline.
* We are a **Specialist Maternal Mental Health Service providing multidisciplinary care to women experiencing PTSD as a result of birth trauma, perinatal loss and/or severe tokophobia (fear of pregnancy and childbirth).** More information on eligibility criteria can be found in our leaflet or on our website via [KMPT | Thrive - Psychological Support for Birth Trauma and Loss](https://www.kmpt.nhs.uk/our-services/thrive-psychological-support-for-birth-trauma-and-loss/)
* **Consultation** **with one of our clinicians prior to referral** is kindly requested. Please call 01227 768928 to arrange.
* **Please ensure the service user has provided consent** for the following;
* To make this referral to Thrive
* For Thrive clinicians to make contact with the service user
* For Thrive clinicians to liaise with the referrer to consider the most suitable care for the service user

**Please send completed referrals to: kmpt.thrivemhsupport@nhs.net**

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| **MENTAL HEALTH NEEDS/RISK** | | | | | |
| **Thrive only supports those identified as low psychological risk** - low risk of harm to self and others, sufficiently stable to engage in intensive trauma interventions, able to effectively recognise and regulate emotions and keep themselves safe. We kindly ask you to book a consultation with Thrive if you would like to discuss this on a case by case basis if you have any queries.  **Please tick this box if you consider the service user to be low psychological risk.** | | | | | |
| **REFERRER DETAILS** | | | | | |
| **Date of referral:** |  | | | | |
| **Your name:** |  | | | | |
| **Your job title:** |  | | | | |
| **Your organisation:** |  | | | | |
| **Your contact details** (work phone number and work email): | | |  | | |
| **Name of Thrive clinician you consulted with prior to making this referral:** | | |  | | |
| **SERVICE USER DETAILS / BACKGROUND** | | | | | |
| **Full Name:** |  | **Nationality:** | |  | |
| **Date of birth:** |  | **Preferred language:** | |  | |
| **NHS Number:** |  | **Interpreter required?** | |  | |
| **Telephone number(s):** |  | **Consent to leave voicemail messages?** | | **Yes** | **No** |
| **Consent to send text messages?** | | **Yes** | **No** |
| **Address & postcode:** |  | **Consent for virtual appointments via Teams if required?** | | **Yes** | **No** |
| **Email Address:** |  | **Consent for email correspondence?** | | **Yes** | **No** |
| **GP Practice:** |  | **Does the client consider themselves as having additional needs?** | |  | |
| **Marital status** |  | **Ethnicity** | |  | |
| **Next of kin / preferred emergency contact** (name, phone number, email address): |  | | | | |
| **Has the service user provided verbal consent for the above to be contacted, if needed?** |  | | | | |
| **Has the service user had any children?** Please choose from the following: | Yes, the service user does have children, if so, does the child(ren) currently live with the service user? (If no, please state where they are residing currently):  Yes, but stillborn  Yes, but died following birth  No, the service user has not had any children | | | | |
| **Is the service user currently pregnant? If yes, please give EDD:** |  | | | | |
| **Is the service user currently receiving any care or support from other professionals**, i.e. social care, GP, Midwife, Health Visitor, mental health team? |  | | | | |
| **Is the service user currently prescribed any medications**? If so, please state below: |  | | | | |
| **Please provide details of any physical health condition(s) we should be aware of:** |  | | | | |
| **REASON FOR REFERRAL** | | | | | |
| **Which of the following has this service user experienced?** (the primary reason for referral to Thrive). Please tick: | Perinatal loss at any gestation  Birth trauma  Repeated unsuccessful IVF  Repeated miscarriage  Termination of pregnancy for any reason  Severe tokophobia (fear of pregnancy and childbirth)  Parent infant separation at birth (including babies removed for childcare proceedings)  Other (please state)  Please make comments if needed: | | | | |
| **Please indicate which PTSD symptoms are present for this service user** | Reliving (e.g. flashbacks, nightmares, repetitive intrusive distressing images or sensations)  Avoidance & emotional numbing (of thoughts/feelings and/or places, people etc)  Hyperarousal (e.g. constantly aware of threats and easily startled)  Negative changes to thoughts/feelings about the trauma that began or worsened because of the event (e.g. unable to remember certain parts, “I am bad”, diminished interest in sig’ activities, detachment) | | | | |
| **What psychological interventions has this service user already had for birth trauma or loss?**  i.e. *Talking Therapies, Counselling, trauma therapy*etc.?  **If no interventions previously, please consider referring to these services in the first instance.** | | | | | |
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| **Please provide a brief summary of your concerns and reason for making this referral**  (e.g. brief description of the trauma if the service user has shared this with you, the symptoms they are experiencing and the impact on their day to day life, and any other information you or the service user feel is relevant for us to know | | | | | |
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