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

**Before making this referral:**

* Thrive is not a crisis service and does not care co-ordinate. If you are concerned about the level of complex need this service user presents with or risk that they pose to themselves or others, or you think they may require crisis support, please liaise with the Single Point of Access service on 0800 783 9111.
* If you are concerned for the physical health of this service user, please liaise with the service user’s GP / primary care healthcare professional.
* Please ensure you have read the Thrive leaflet, which provides further details on who may be eligible/not eligible for the service.
* Please ensure you have gained the service user’s consent:
  + To make this referral to Thrive
  + For Thrive clinicians to make contact with the service user
  + For Thrive clinicians to liaise with other professionals involved in the service user’s care

**Please email completed referral form to: kmpt.thrivemhsupport@nhs.net**

**For advice / support prior to making the referral, please call: 01227 768928**

|  |
| --- |
| **MENTAL HEALTH NEEDS/RISK** |
| Thrive are only able to support service users who are assessed as having low risks to self and others. When considering the service user’s current mental health needs/ risk of self-injury/ suicidal intent/ crisis service needs - do you consider the risks to be low or high?   * Low (e.g. sufficiently stable to engage in intensive trauma interventions, able to effectively recognise and regulate emotions, able to keep themselves safe) * High (Thrive is unable to support service users who are assessed as medium or high risk, please do not make a referral but call if you would like to discuss this further). |
| **REFERRER DETAILS** |
| **Date of referral:** |
| **Referrer’s name:** |
| **Referrer’s job title and profession:** |
| **Referrer’s team and organisation:** |
| **Referrer’s contact details** (phone number and email): |
| **SERVICE USER DETAILS / BACKGROUND** |
| **Forename:** |
| **Surname:** |
| **Date of birth:** |
| **Address** (including postcode): |
| **Telephone number(s):** |
| **Has the service user provided verbal consent for Thrive staff to leave voicemail messages / send text messages to the above?** |
| **NHS Number:** |
| **Marital status:** |
| **Ethnicity:** |
| **Preferred language:** |
| **Interpreter required?** |
| **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 below:  🗆Yes, but stillborn  🗆Yes, but died following birth  If either of the above apply, please provide brief details on date of birth / circumstances:  🗆Yes, the service user does have children  If the above applies, please provide the following:  Names of the child/children:  Sex of the child/children:  Dates of birth and age of the child/children:  Does the child/children currently live with the service user? (If no, please state where they are residing currently):  🗆No, the service user has not had any children |
| **Is the service user currently pregnant? If yes, please give EDD here:** |
| **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:   * Birth loss (stillbirth or bereavement after birth) * Birth trauma (physical, which is causing current emotional distress) * Birth Trauma (emotional, and causing current distress) * Repeated IVF attempts * Repeated miscarriage * Termination of pregnancy * Severe fear of childbirth (Tokophobia) * Parent/infant separation * Other (please state)   Please make comments if needed: |
| **Which interventions has this service user received previously for mental health issues resulting from the above**, i.e. IAPT, Counselling, BTR therapy etc.? If no interventions previously, please consider referring to these services in the first instance. |
| **Please provide a brief history of this service user’s psychiatric / mental health history if there is one, including previous and current episodes of mental ill health** (i.e. mental health diagnoses, previous interventions received, medication prescribed etc.) |
| **Please provide a brief summary of your concerns and reason for making this referral** (e.g. service user’s presentation, information they have provided, how you think they could benefit from a referral to the service: psychological therapy / specialist midwifery therapy, advice or support / peer support / links into reproductive health / other.) |