South Warwickshire NHS
NHS Foundation Trust

Coventry and Warwickshire Partnership NHS
NHS Trust

Referral to Warwickshire Perinatal Mental Health Team

For women aged 16 years and over

Date of Referral: ….\…….\….

PATIENT INFORMATION

Title:		D.O.B.	…….\…….\……
Hospital No.:		NHS No.:	

Patient consent given? Yes ☐ No ☐

Weeks Pregnant /40

Consultant Obstetrician *(if applicable)*

Parity:

Due Date …….\…….\…….

Date Delivered ….\…….\…….

Ethnicity ……

Language Spoken:……

Interpreter Required Yes ☐ No ☐ N/A ☐

Surname:

Forename:

Address:

Post Code

☎

REFERRER DETAILS

Name:

Designation:

Address:

Post Code

☎

GENERAL PRACTITIONER DETAILS

Name:

Surgery

Address:

Post Code

☎

Current Symptoms – Please tick relevant boxes

☐ Psychotic Symptoms

☐ Strong suicidal thoughts or plans

☐ Hostile thoughts about baby with intent to harm the baby.

If any of the above are present, at any stage of pregnancy or up to 6 months postnatally, please complete the form and fax or ☎ the referral to

Warwickshire
☎ 0300 200 0011
Fax No: 024 7696 1560

The perinatal team will consider patients who have these issues **beginning perinatally** (i.e in pregnancy or first 6 postnatal months)

☐ Severe bonding issues / mother-infant attachment issues
☐ Severe depressive illness / feels depressed or low in mood
☐ Occasional suicidal thoughts –but no real plans
☐ Mood swings
☐ Family history of bipolar disorder
☐ 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
☐ Mental illness impacting on medical care such as needle phobia
☐ Labour or postnatal related post-traumatic symptoms
☐ Complicated/unusual response to stillbirth or neonatal loss
☐ Difficulty adjusting to a medically complicated pregnancy eg. multiple pregnancy or placenta praevia
☐ Past postnatal depression requiring hospitalisation
☐ Past postnatal depression, no hospitalisation
☐ History of psychosis (may be postnatal or not)
☐ **Or prior to conception** with a history of schizoaffective disorder, bipolar disorder or severe depressive illness requiring hospitalisation

Other Issues – Please tick relevant boxes

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 serious psychiatric illness i.e. mania, depression or schizophrenia
☐ Partner has a serious mental illness (as above)
☐ Feels socially isolated
☐ Child protection involvement with any child
☐ Current or 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 Postnatal Depression/Psychosis, Outpatient, Inpatient or Day care and dates including treatments given and by whom.

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

Living with patient ☐Yes ☐No

Children living with patient ☐Yes ☐No

If yes, names and age of children
……
……
……

ANY CURRENT SOCIAL STRESSES……
……
……

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?

Signature of referrer……

Name in block capitals……**Date**……..

☞ *Please return this form to*

Perinatal Mental Health Team
Warwick Hospital
Psychology Department
Lakin Road
Warwick
CV34 5BW

or

Fax 01926 608058
Email: PMHT@swft.nhs.uk

(Telephone: 01926 495321 X.4417)