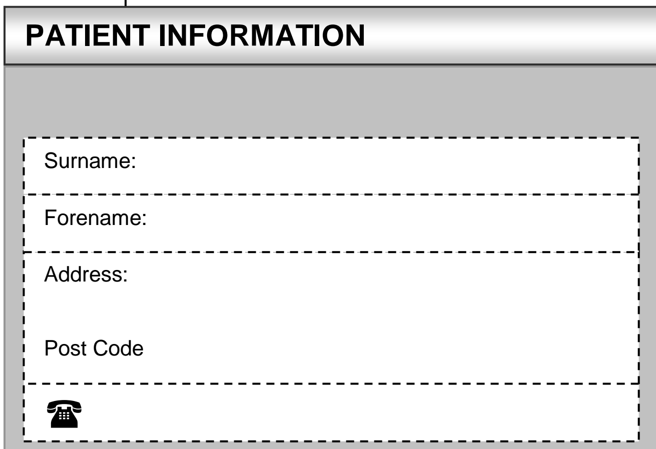
South Warwickshire NHS
NHS Foundation Trust

Coventry and Warwickshire Partnership NHS
NHS Trust

Referral to Coventry and Rugby Perinatal Mental Health Team

For women aged 16 years and over

Date of Referral: ….\…….\….



PATIENT INFORMATION

Surname:

Forename:

Address:

Post Code

☎

Title:

D.O.B. …….\…….\……

Hospital No.:

NHS No.:

Patient consent given? Yes ☐ No ☐

Weeks Pregnant /40

Consultant Obstetrician *(if applicable)*

Parity:

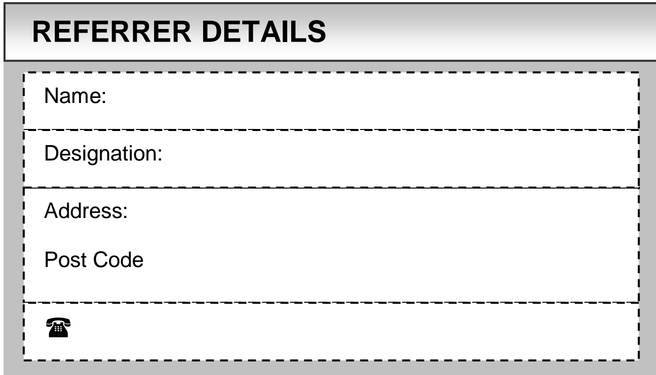
Ethnicity ……………………………………

Language Spoken:………………………

Interpreter Required Yes ☐ No ☐ N/A ☐

Due Date …….\…….\…….

Date Delivered ….\…….\…….



REFERRER DETAILS

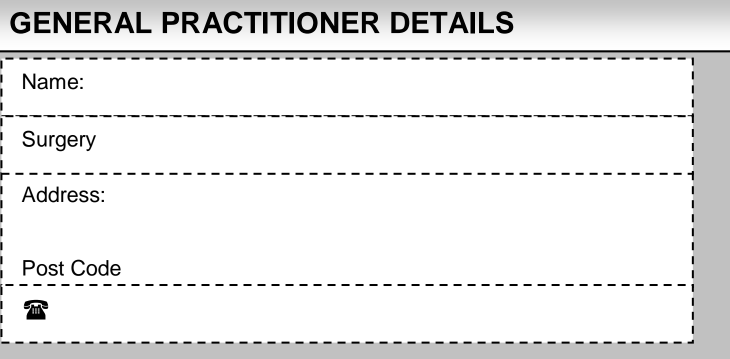
Name:

Designation:

Address:

Post Code

☎



GENERAL PRACTITIONER DETAILS

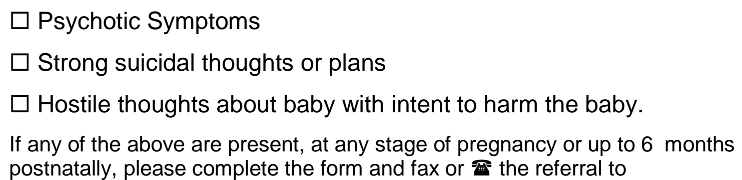
Name:

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

Coventry / Rugby
☎ 0300 200 0011
Fax No: 024 7696 1560

The perinatal team will consider patients who have these issues **beginning perinatally** (ie 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
Willenhall Health Centre
Remembrance Road
Coventry
CV3 3DG

or

Fax: 024 7684 3104
Email: PMHT@covwarkpt.nhs.uk

(Telephone: 024 7621 2176)